First Health Services Corporation®
A Coventry Health Care Company

Provider Enrollment

VaMMIS Procedure Manual

Version 1.0

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HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	01/04/08	[redacted] Documentation Mgmt. Team	Creation of document

Table of Contents

HIPAA Privacy Rules 4
Revision History 5
Table of Contents 6
Preface 8
Use and Maintenance of this Manual 8
Manual Revisions 8
Flowchart Standards 9
1.0 Overview of the Virginia Medical Assistance Program 10
1.1 Standard Abbreviations for Subsystem Components 10
1.2 Covered Services 11
1.3 Waivers and Special Programs 13
1.4 Eligibility 15
1.5 Eligible Providers and Reimbursement 16
2.0 Receive and Control Provider Enrollment Mail 18
2.1 Open and Sort Provider Enrollment Mail 20
2.2 Batch Mail 22
2.3 Prepare Mail for Scanning 23
2.4 Log-In Inventory Control 23
2.5 Batch Returned Mail 24
3.0 Scan Mail 25
3.1 Scan Documents 27
3.2 Index Scanned Documents 27
3.3 Process Outgoing Mail 30
4.0 Enroll Providers 31
4.1 Review the Provider Application 33
4.2 Check the Applicant's Current Status 36
4.3 Check Provider Sanction/Exclusion 37
4.4 Verify Licensing Requirements 41
4.5 Complete Screens to Enroll a Provider 42
4.6 Evaluate the Provider Application for EDI/EFT/POS Registration 44
4.7 Finalize Batch Review and Quality Control 44
5.0 Maintain the Provider Database 46
5.1 Enter Provider Enrollment Tracking Data 52
5.2 Enter Provider Enrollment Information 53
5.3 Enter Provider Address Data 54
5.4 Enter Provider Change Data 55
5.5 Enter Provider Cancel Data 56
5.6 Enter Provider Reinstate Data 57
5.7 Enter Provider Group Data 58

5.8 Enter Provider Affiliation Data 59
5.9 Enter Provider Medicare Cross Reference Data 60
5.10 Enter Provider Rate Data 61
5.11 Enter Provider CLIA Data 61
[redacted] 62
6.0 Maintain Provider Enrollment Documentation 71
6.1 Prepare Provider Documentation for Storage 71
6.2 Prepare Batches of Provider Documentation for Disposal 71
6.3 List of Provider Agreements 71
7.0 Service the Provider Helpline 75
7.1 Login and Logout of the Computer System 75
7.2 Login and Logout of the Phone System 75
7.3 Respond to Incoming Calls 76
7.4 Make Outgoing Calls 79
7.5 Use Professional Telephone Techniques 80
8.0 Provide Assistance to DMAS 85
8.1 Assist DMAS with Liaison and Coordination 85
8.2 Assist DMAS with Resolution of Concerns and Appeals 85
Appendix A HIPAA Privacy Rules 87
Appendix B Weekly DHP Update Instructions 88
Appendix C U.S. Postal Standards 91
Appendix D Provider Enrollment Unit Post NPI Implementation Procedures Manual
Appendix E Detailed Enrollment Manual
Appendix F Provider Groups Enrollment Manual

Preface

The Procedures Manual for the Virginia Medicaid Management Information System (VaMMIS) is a product of First Health Services Corporation. Individual manuals comprise the series of documents developed for the operational areas of the VaMMIS project. Each document includes an introduction, a functional overview of the operations area, workflow diagrams illustrating the processing required to accomplish each task, and descriptions of relevant inputs and outputs. Where appropriate, decision tables, lists, equipment operating instructions, etc. are presented as exhibits, which can be photocopied and posted at unit workstations. Relevant appendices containing information too complex and/or lengthy to be presented within a document section are included at the end of the document.

Use and Maintenance of this Manual

The procedures contained in this manual define day-to-day tasks and activities for the specified operations area(s). These procedures are based on First Health Services' basic MMIS Operating System modified by the specific constraints and requirements of the Virginia MMIS operating environment. They can be used for training as well as a source of reference for resolution of daily problems and issues encountered.

The unit manager is responsible for maintaining the manual such that its contents are current and useful at all times. A hardcopy of the manual is retained in the unit for reference and documentation purposes. The manual is also available on-line for quick reference, and users are encouraged to use the on-line manual. Both management and supervisory staff are responsible for ensuring that all operating personnel adhere to the policies and procedures outlined in this manual.

Manual Revisions

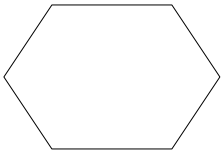
The unit manager and supervisory staff review the manual once each quarter. Review results are recorded on the Manual Review and Update Log maintained in this section of the document. Based on this review, the unit manager and supervisory staff determine what changes, if any, are necessary. The unit manager makes revisions as applicable, and submits them to the Executive Account Manager for review and approval. All changes must be approved by the Executive Account Manager prior to insertion in the manual. When the changes have been approved, the changes are incorporated into the on-line manual. Revised material will be noted as such to the left of the affected section of the documentation, and the effective date of the change will appear directly below. A hardcopy of the revised pages are inserted into the unit manual, and copies of the revised pages are forwarded to all personnel listed on the Manual Distribution List maintained in this section of the manual.

Flowchart Standards

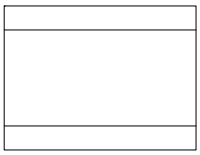
The workflow diagrams included in this document were generated through the flowcharting software product Visio Professional. Descriptions of the basic flowcharting symbols used in the VaMMIS documentation are presented below.

Large Processing Function

Manual Process. No automated processes are used; e.g., clerical function.

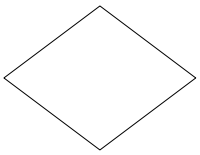


Data Preparation Processing; e.g., mailroom, computer operations, etc.

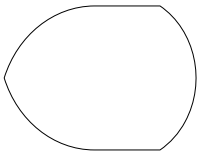


Create a Request

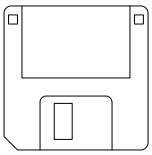
Data maintained in a master datastore.



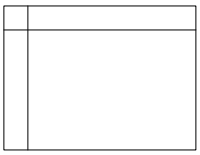
Decision



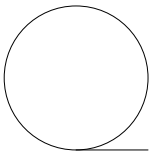
Information entered or displayed on-line.



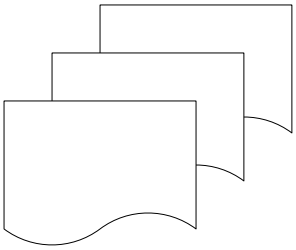
Data stored on diskette media.



On-line Storage; e.g., CD-ROM, microform, imaged data, etc.

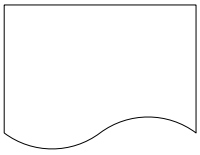


Input or Output Tape



Multiple Outputs; e.g., letters, reports

Communication Link



Single Output; e.g., letter, report, form, etc.

External Entity. Source of entry or exit from a process.

Off-page Connector

1.0 Overview of the Virginia Medical Assistance Program

The Commonwealth of Virginia State Plan under Title XIX of the Social Security Act sets forth the Commonwealth's plan for managing the Virginia Medical Assistance Program (VMAP). It defines and describes the provisions for: administration of Medical Assistance services; covered groups and agencies responsible for eligibility determination; conditions of and requirements for eligibility; the amount, duration, and scope of services; the standards established and methods used for utilization control, the methods and standards for establishing payments, procedures for eligibility appeals; and waivered services.

1.1 Standard Abbreviations for Subsystem Components

For brevity, subsystem components will use these abbreviations as part of their nomenclature.

Abbreviation	Subsystem
AM	Automated Mailing
AS	Assessment (Financial Subsystem)
CP	Claims Processing
DA	Drug Application
EP	EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
FN	Financial Subsystem
MC	Managed Care (Financial Subsystem)
MR	MARs (Management and Reporting)
POS	Point of Sale (Drug Application)
PS	Provider
RF	Reference
RS	Recipient
SU	SURS (Surveillance Utilization and Review)
TP	TPL (Financial Subsystem)

1.2 Covered Services

The Virginia Medical Assistance Program covers all services required by Federal legislation and provides certain optional benefits, as well. Services are offered to Medicaid Categorically Needy and Medically Needy clients. In addition, certain services are provided to eligibles of the State and Local Hospitalization (SLH) program and the Indigent Health Care (IHC) Trust Fund. SLH, Temporary Detention Orders (TDO), and IHC are State and locally funded programs with no Federal matching funds. SLH is a program for persons who are poor, but not eligible for Medicaid in Virginia, which is funded by the Commonwealth and local counties.

Services and supplies that are reimbursable under Medicaid include, but are not limited to:

- Inpatient acute hospital
- Outpatient hospital
- Inpatient mental health
- Nursing facility
- Skilled nursing facility (SNF) for patients under 21 years of age
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Hospice
- Physician
- Pharmacy
- Laboratory and X-ray
- Clinic
- Community mental health
- Dental
- Podiatry
- Nurse practitioner
- Nurse midwife
- Optometry
- Home health
- Durable medical equipment (DME)
- Medical supplies
- Medical transportation
- Ambulatory surgical center.

Many of the services provided by DMAS require a co-payment to be paid by the recipient. This payment differs by type of service being billed, according to the State Plan. Payment made to providers is the net of this amount.

General exclusions from the Medicaid Program benefits include all services, which are experimental in nature, cosmetic procedures, acupuncture, autopsy examination, and missed appointments. In addition, there are benefit limitations for specific service categories that must be enforced during payment request processing.

1.3 Waivers and Special Programs

In addition to the standard Medicaid benefit package, the Commonwealth has several Federal waivers in effect which provide additional services not ordinarily covered by Medicaid, as well as special programs for pregnant women and poor children. The programs include:

- **Elderly and Disabled** is a Home and Community Based Care (HCBC) waiver program covering individuals who meet the nursing facility level-of-care criteria and who are at risk for institutionalization. In order to forestall institutional placement, coverage is provided for:
  - Personal Care (implemented 1982)
  - Adult Day Health Care (implemented 1989)
  - Respite Care (implemented 1989)
- **Technology Assisted Waiver for Ventilator Dependent Children** is a HCBC waiver implemented in 1988 to provide in-home care for persons under 21, who are dependent upon technological support and need substantial ongoing nursing care, and would otherwise require hospitalization. The program has since been expanded to provide services to individuals over age 21.
- **Mental Retardation Waiver** includes two HCBC waivers that were implemented in 1991 for the provision of home and community based care to mentally retarded clients. They include an OBRA waiver for persons coming from a nursing facility who would otherwise be placed in an ICF/MR, and a community waiver for persons coming from an ICF/MR or community. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) updates the eligibility file for Mental Retardation Waivers.
- **AIDS/HIV Waiver** is a HCBC waiver implemented in 1991 that provides for home and community based care to individuals with AIDS, or who are HIV positive, and at risk for institutionalization.
- **Assisted Living Services** include two levels of payment, regular and intensive. Regular assisted living payments (per day per eligible recipient) are made from state funds. Intensive assisted living payments (per day per eligible recipient) are covered under an HCBC waiver and are made from a combination of state and federal funds.
- **Adult Care Resident Annual Reassessment and Targeted Case Management** provides for re-authorization and/or follow-up for individuals residing in assisted living facilities. The program includes a short assessment process for individuals who are assessed at the residential level, and a full assessment for individuals who are assessed at the regular or intensive assisted living level. The targeted case management is provided to individuals who need assistance with the coordination of services at a level which exceeds that provided by the facility staff.

- **PACE/Pre-PACE Programs** provide coordination and continuity of preventive health services and other medical care, including acute care, long term care and emergency care under a capitated rate.
- **Consumer-Directed Personal Attendant Services** is a HCBC waiver that serves individuals who are in need of a cost-effective alternative to nursing facility placement and who have the cognitive ability to manage their own care and caregiver.
- **MEDALLION Managed Care Waiver** is a primary care physician case management program. Each recipient is assigned a primary care physician who is responsible for managing all patient care, provides primary care, and makes referrals. The primary care physician receives fees for the services provided plus a monthly case management fee per patient.
- **MEDALLION II Managed Care Waiver** is a fully capitated, mandatory managed care program operating in various regions of the State. Recipients choose among participating HMOs, which provide all medical care, with a few exceptions.
- ***Options*** is an alternative to MEDALLION where services are provided through network providers, and the participating HMOs receive a monthly rate based on estimated Medicaid expenditures.
- **Client Medical Management (CMM)** is the recipient "lock-in" program for recipients who have been identified as over utilizing services or otherwise abusing the Program. These recipients may be restricted to specific physicians and pharmacies. A provider who is not the designated physician or pharmacy can be reimbursed for services only in case of an emergency, written referral from the designated physician, or other services not included with CMM restrictions. The need for continued monitoring is reviewed every eighteen (18) months.

  The services not applicable to CMM are renal dialysis, routine vision care, Baby Care, waivers, mental health services, and prosthetics.

- **Baby Care Program** provides case management, prenatal group patient education, nutrition counseling services, and homemaker services for pregnant women, and care coordination for high risk pregnant women and infants up to age two.

1.4 Eligibility

Medicaid services are to be provided by eligible providers to eligible recipients. Eligible recipients are those who have applied for and have been determined to meet the income and other requirements for the Department of Medical Assistance Services (DMAS) services under Medicaid. Virginia also allows certain Social Security Income (SSI) recipients to "spend down" their income to Medicaid eligibility levels by making periodic payments to providers.

Virginia is a Section 209(b) state, meaning that the DMAS administers Medicaid eligibility for SSI eligibles and State supplement recipients locally through the Department of Social Services (DSS). DSS administers eligibility determination at its local offices and is responsible for determining Medicaid eligibility of Temporary Assistance to Needy Families with Children (TANF), Low-Income Families with Children (LIFC), and the aged. DSS also determines financial eligibility of blind and disabled applicants. In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) administers recipient eligibility for Mental Retardation Waivers. The Department of Visually Handicapped (DVH) and the Department of Rehabilitative Services (DRS) are responsible for determining the degree of blindness of an applicant and the determination of medical necessity, respectively.

Three categories of individuals are eligible for services under the VMAP: Mandatory Categorically Needy, Optionally Categorically Needy, and Optionally Medically Needy. In addition, DMAS operates two other indigent healthcare financing programs, the State and Local Hospitalization (SLH) and the Indigent Health Care (IHC) Trust Fund.

1.5 Eligible Providers and Reimbursement

Qualified providers enroll with the VMAP by executing a participation agreement with the DMAS prior to billing for any services provided to Medicaid eligibles. Providers must adhere to the conditions of participation outlined in the individual provider agreement. To be reimbursed for services, providers must be approved by the Commonwealth and be carried on the Provider Master File in the MMIS.

DMAS employs a variety of reimbursement methodologies for payment of provider services. Inpatient hospital and long-term care facilities are reimbursed on a per diem prospective rate, which goes into effect up to 180 days after the beginning of the rate period to allow for retroactive payment adjustments. Settlement is based on a blend of the per diem rate and the APG/DRG Grouper reimbursement methodology. Other providers are reimbursed on a fee-for-service (FFS) basis according to a Geographic Fee File maximum amount allowed. In the FFS methodology, payment is the allowed amount, or the charge, whichever is less; payment is adjusted by co-payment, as well as by any third-party payment. Medicare co-insurance and deductibles received in the crossover system are reduced to the Medicaid allowance when the Medicare payment and the Medicaid co-insurance amount would exceed the Medicaid-allowed amount. In addition to these payment methodologies, the MEDALLION managed care program uses case management fees as well as FSS. MEDALLION II is fully capitated and uses a per member, per month, payment methodology. Health maintenance organizations (HMOs) participating in the *Options* program are paid a monthly rate based on estimated Medicaid expenditures. Monthly fees are also paid for Client Medical Management (CMM).

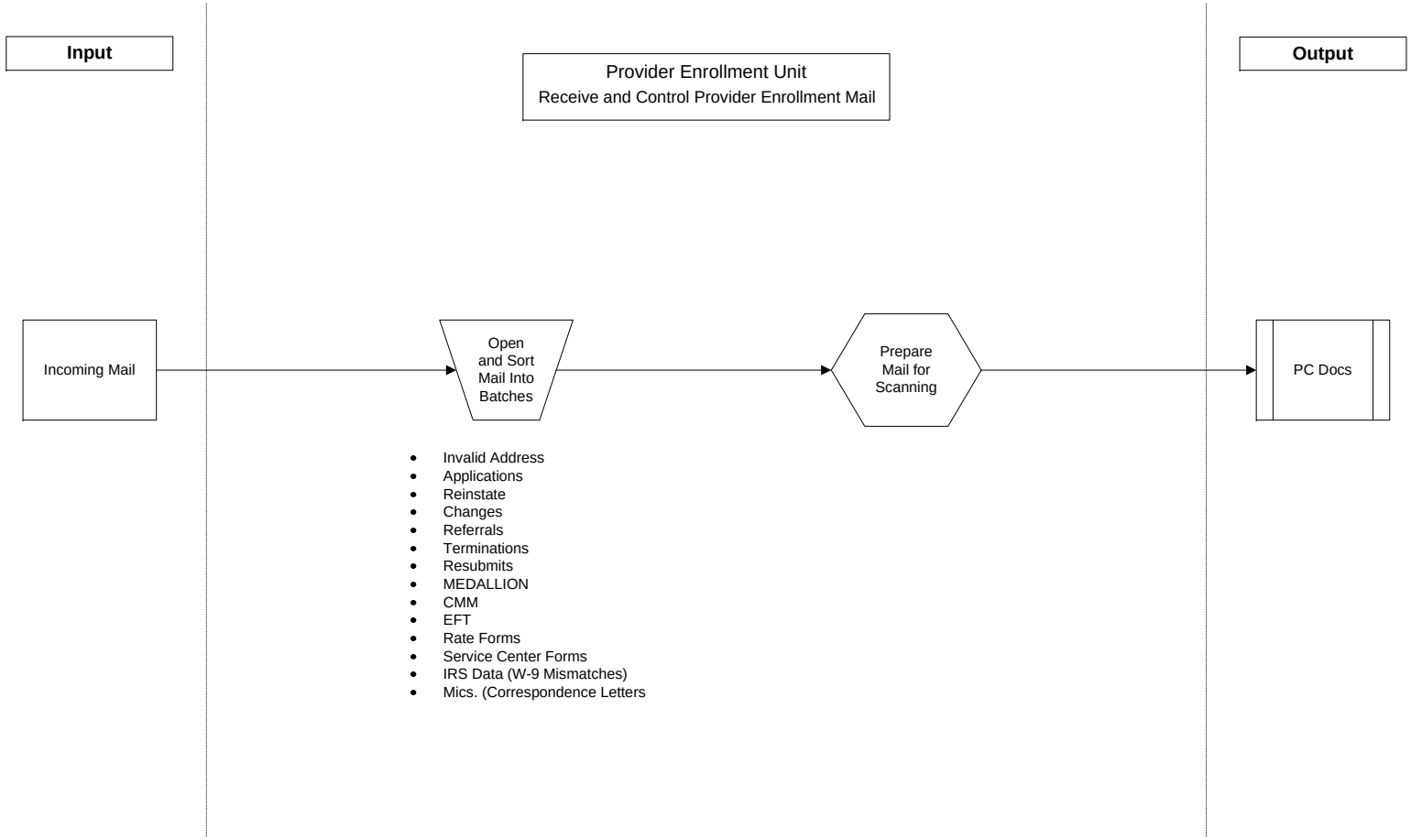
2.0 Receive and Control Provider Enrollment Mail

The PEU (Provider Enrollment Unit) is responsible for both original and returned Provider Enrollment mail delivered to First Health. The unit receives all mail containing Provider Enrollment forms, updates and changes to the MMIS and prepares these documents for scanning. An essential part of the control of Provider Enrollment forms is the maintenance of logs of all paper documents received so their disposition can be tracked.

Note: Sample Log Sheets are at the end of this Section

WORKFLOW PROCESS

Input Control Procedures: Receive and Control Provider Enrollment Mail



2.1 Open and Sort Provider Enrollment Mail

The procedures in this section contain the tracking mechanism for the Provider Enrollment Unit (PEU) mail. Sorting the documents by type supports subsequent batching and preparation of documents for scanning and final disposition. Mail is received daily from the Post Office. The mail is opened and the envelopes disposed of before sorting and routing. The PEU Unit routinely receives the following types of Provider Enrollment documents:

- Nursing Home, new requests and changes
- New Enrollment Requests
- Provider Change Requests
- Provider Correspondence
- Provider Cancel Requests
- Medallion Requests
- Re-certifications
- Re-submissions
- EDI Requests
- W-9 Requests
- EFT Requests
- Provider Rate for Cost Settlement Providers Form
- Returned Mail

Note: If there is mail for more than one day, the oldest is processed first, still using the Julian day it was actually received.

Procedure

1. Express or certified mail is logged in the Corporate Mail Room and delivered to the PEU upon receipt.
2. If this type of mail is addressed to a staff member, it is given to that person immediately for review.
3. Mail from the Post Office and state agencies is delivered twice daily by the company courier. Mail from all other sources, including facsimiles, is received throughout the business day.
4. At 10:00 a.m. daily the Document Control Clerk begins the process of sorting and batching the mail. All mail/facsimiles received after twelve noon are held for processing the following business day.

- ❖ Document Control staff are the only authorized persons to handle the mail and facsimiles.

5. Facsimiles are removed from the incoming machine periodically throughout the day. The staff must notify the Document Control clerks when a fax is expected and it will be delivered at the next pick -up time.
6. Mail addressed to staff from providers is presented to the staff member but must be returned to Document Control for centralized processing. If mail is urgent, the staff takes the appropriate action and places the documents in the Profile Only basket.
7. Open the envelopes and dispose of the empty envelope in the appropriate trash receptacle
8. Remove all fasteners from the document
9. Sort the mail according to type, placing the different types of documents (Provider Applications, Provider Change Requests, Cancel etc.) in the appropriate basket.
    - ❖ Nursing Home (0)
        - – Nursing Home participation agreements or supporting documentation
    - ❖ Add (1)
        - – Agreement forms and Applications without a provider number
    - ❖ Changes (2)
        - – Copy of license
        - – Any other form attached (Not EFT)
        - – Requests for Title XVIII Information
    - ❖ Correspondence (3)
        - – Memo or letter
    - ❖ Terminations (4)
    - ❖ Medallion (5)
        - – Medallion agreement attached
        - – Medallion box checked on the agreement
    - ❖ Re-certification (6)
        - – Agreement form with a provider number. May have a re-certification letter attached
    - ❖ Re-submissions (7)
        - – RESUBMISSION written on the agreement
        - – Address on the envelope is the Resumission Post Office Box
    - ❖ W-9 (8)

- Requests for Tax ID corrections

❖ Mental Health (multiple types)

- M/R Waiver participation agreements or supporting documentation

❖ EFT (send to EFT Coordinator)

❖ EDI (send to EDI Coordinator)

❖ Returned Mai

❖ Mail returned to First Health or DMAS due to an undeliverable address

2.2 Batch Mail

Procedure

10. Create batches of 10 documents each by type
11. Complete a Batch Cover Sheet for each batch

❖ Choose the appropriate color

- Pink – Medallion
- Blue - Resubmits
- Gold - Nursing Home and Rates
- Yellow - Mental Health
- White - all others

❖ Enter the batch number (YJJJTNN)

- Last Position of the year
- Julian Date of the year
- Transaction Type
  - Nursing Home (0)
  - Add (1)
  - Changes (2)
  - Correspondence (3)
  - Terminations (4)
  - Medallion (5)
  - Re-certification (6)
  - Re-submissions (7)
  - W-9 (8)
  - Mental Health (multiple types)

- (11) EFT (send to EFT Coordinator)
- (12) EDI (send to EDI Coordinator)
- (13) Returned Mail iv) Batch Number

– Batch Number

❖ Enter the processor's initials and date in the Document Control receipt box.

12. Place the documents in the scanning receptacle

2.3 Prepare Mail for Scanning

Your goal is “one-pass” scanning, meaning the document will be scanned and you will get an acceptable image from the scan on one pass of the scanner.

Procedure

1. Shuffle the documents, making sure the tops of the documents are all evenly aligned.
2. Place the stack of documents into the scanner receiver tray.
3. Start the scanning program.

2.4 Log-In Inventory Control

An Inventory Control Form accompanies each document type throughout the processing cycle of the documents. The control totals for each batch are written on the Inventory Control Log and on the batch tickets.

- Input prep count
- Imaged count
- Indexed count
- Representative disposition count

The counts on both control documents must be equal. After each batch is imaged, the documents in a batch are counted. This total must match the total on the batch ticket and discrepencies noted throughout the process.

Note: Each day, a copy of the Inventory Control Form must be given to the Quality Control Lead.

Procedure

1. Take the Inventory Control Form and place it next to the batch ticket

2. Check each of these counts to make sure the count on the Inventory Control Form matches the batch ticket.
    - ❖ Input prep count
    - ❖ Imaged count
    - ❖ Indexed count
3. If the counts do NOT match, check for pulled documents in the batch.
4. Enter any pulled documents into the [redacted] program.
5. If the counts do match, sign the Inventory Control Form.
6. Place the batch in the area for processing.

2.5 Batch Returned Mail

Some mail the PEU receives has been returned to First Health because the address was missing or invalid or the addressee was not at the address. The PEU processes this returned mail irrespective of the source. Returned mail addressed to recipients is forwarded to the DMAS Customer Service Unit for changes to mailing addresses or further processing.

Procedure

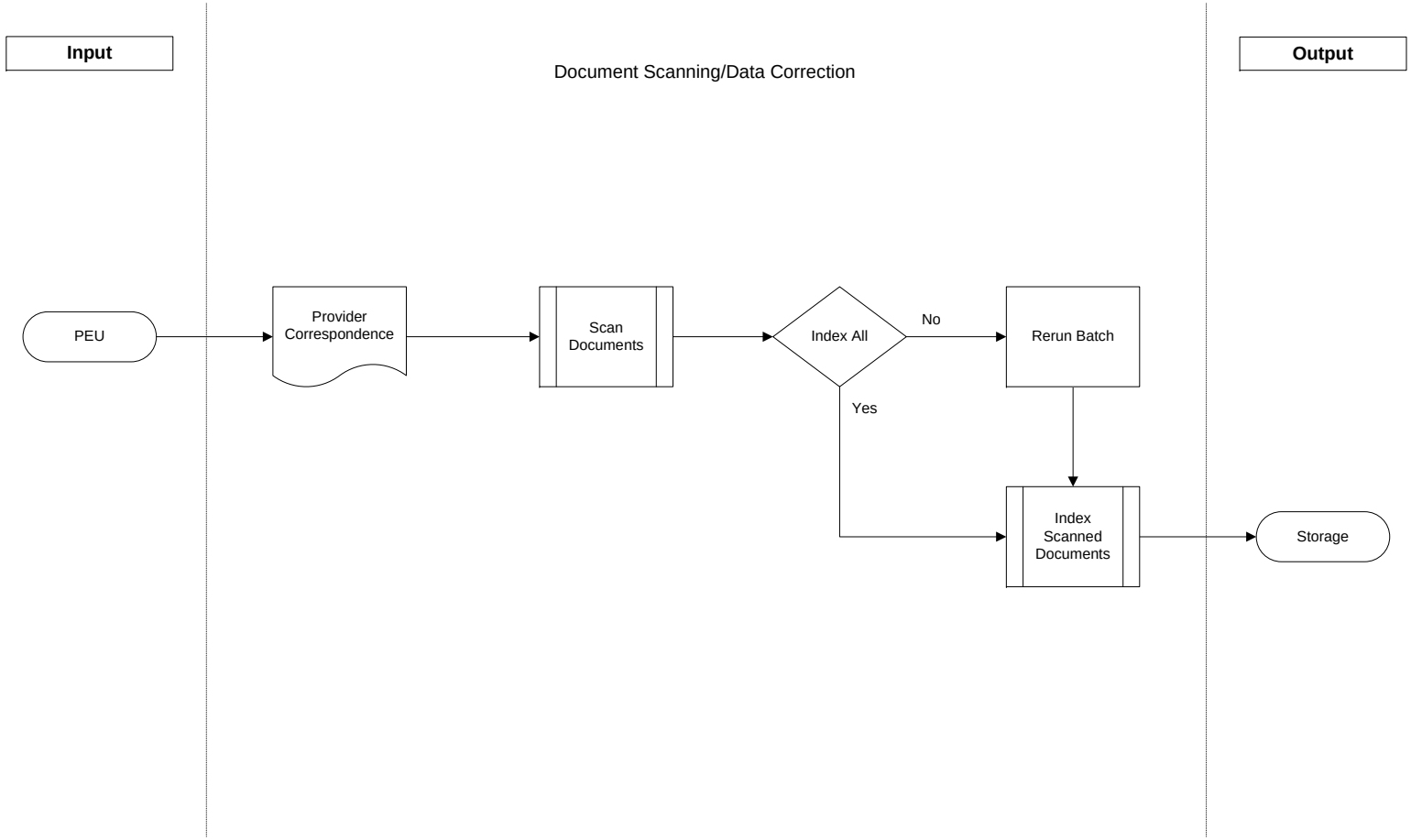
1. Keep the mail in its original envelope.
2. Separate the mail into stacks of 20 pieces and put a rubber band around each stack
    - ❖ Batch returned RAs seperately
    - ❖ Pull ID cards and deliver to the Data Prep Supervisor
    - ❖ Pull Recipient mail and bundle for DMAS
3. Count the pieces of mail and write the count on the daily report.
4. Write the Julian date, the actual date and the count on a Document Control Batch Sheet for each batch.
5. Take batches to the **Holding Shelf** to await processing by designated staff.

3.0 Scan Mail

Mail is scanned daily upon completion of the sorting and batching process. The integrity of the batches is maintained throughout the scanning process.

WORKFLOW PROCESS

Provider Enrollment Procedures: Scan Mail



3.1 Scan Documents

All enrollment documents are scanned and profiled for viewing in PC Docs. As soon as a document is scanned the scan in immediately available for viewing.

Procedure

1. Turn the scanner to the [redacted] position by flipping the switch (located on the left front of the machine)
2. The lighted indicators on the right side of the control panel should be set for routine scanning.
3. Load documents into the appropriate feed tray:
   - ❖ For automatic feed, load documents on the lower right of the filmer and press the [redacted] button (the far right button on the top lower right panel).
   - ❖ For single document feed, insert one by one into the manual feed port located directly above the document feed tray (The [redacted] button does not need to be pressed as it will be tripped each time a document is inserted).
4. Scanning can be halted at any time by pressing the [redacted] button located beside the [redacted] button.
5. After the documents are scanned, they pass through the printer and are released into the collection tray located underneath the scanner.
6. Record the number of pieces of paper and the time on the Batch Cover Sheet.
7. Place the documents in a [redacted] bin, until all the scanned documents are indexed.

3.2 Index Scanned Documents

When a document is scanned, the profile is indexed with the provider name, provider number (if, available), document type, document name and logon ID. After you enroll a provider, you must add the provider number to the scanned documents

Note: A list of [redacted] document type codes/identifiers follows this section.

Procedure

1. Cancel out of Novell.
2. Enter the Windows password (see Log in Screens list).
3. Enter network password.
   - ❖ Delete the password.

- ❖ Take the check mark off **Save This Password**.
- ❖ Choose **OK**.

4. Double click on [redacted].
   - ❖ Enter the User Name (see Login Screen list).
   - ❖ Enter Password (same as the User Name from list).
   - ❖ Click on [redacted].

[redacted]

   - ❖ Open up the Application List.
   - ❖ Double click on [redacted].

[redacted]

   - ❖ Click the [redacted] icon.
   - ❖ Click **Yes**.
   - ❖ HP ScanJet setting, click **OK**.

7. [redacted].
   - ❖ Take the check mark off [redacted].
   - ❖ Find the date, time and page count for the batch.
   - ❖ Proceed to Index.
     - – Use the left mouse button to click on the desired Scan. If several Scans need to go into the same folder, i.e. multiple claims, hold down the **CTRL** key and click on each Scan or click on first Scan and hold down the **Shift** key and click on the last Scan.
     - – Use the right mouse button to view the options. The options are:
       - [redacted] - Use this if you need to place the same Scan in more than one provider's folder.
       - [redacted] - Use this if you need to profile the Scan in one folder. This is used the majority of the time.
     - – Fill in the boxes when the [redacted] box appear.
       - Type the provider number without spaces or dashes, if given
       - Type the provider name in lower case. Last name, first name, middle initial. Do not use punctuation except for hyphenated last names.
       - Type the 2 digit code identifying the document type
       - Press **Enter**

- Begin again with the next document. When the last document is reached it must be selected by [redacted], **Save** to access the [redacted] box
- When finished, close [redacted] by clicking the **X** in the right corner.

[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

3.3 Process Outgoing Mail

All outgoing mail must be prepared for posting prior to sending the mail to the Mail Room.

Procedure

1. Place all enrollment documents and attachments in the **To Be Copied and Mailed** basket.
2. Copy signed agreement and place the copy in the **To Be Scand** basket.
3. Fold mail packet and place in envelope with the address clearly showing in the window.
4. Do not seal the envelope. Leave the flap open.
5. Place in the **Outgoing** box for the courier.

4.0 Enroll Providers

Provider applications are received daily by the First Health Provider Enrollment Unit (PEU). DMAS has adopted the NPI as the standard for identifying all participating providers on all transactions (Automated Response System, Claims, Prior Authorizations), including paper claims, for all DMAS Programs (Medicaid, FAMIS, SLH, and TDO). Participating DMAS providers who are not defined as health care providers by CMS (http://www.dmas.virginia.gov/npi-home_page.htm) and therefore ineligible to obtain an NPI will be issued a Virginia Medicaid specific API (Atypical Provider Identifier) that will be used in the same manner as an NPI. Therefore, all servicing locations and provider types for an individual provider or Group Practice will be associated with a single NPI or API. The application is reviewed for the required data and attachments, such as professional license or certification, to determine the status of the application.

If the application meets the DMAS Program and Provider Type requirements, the approved application data is ready to be entered in the VA DMAS Provider database using the Provider on-line screens. An approval letter will be systemgenerated informing the provider of the VA DMAS Provider ID with effective date and the program name of the provider enrollment. If the application does not meet the DMAS Program and Provider Type requirements, the provider application is returned to the provider with a letter indicating the reasons the application was denied.

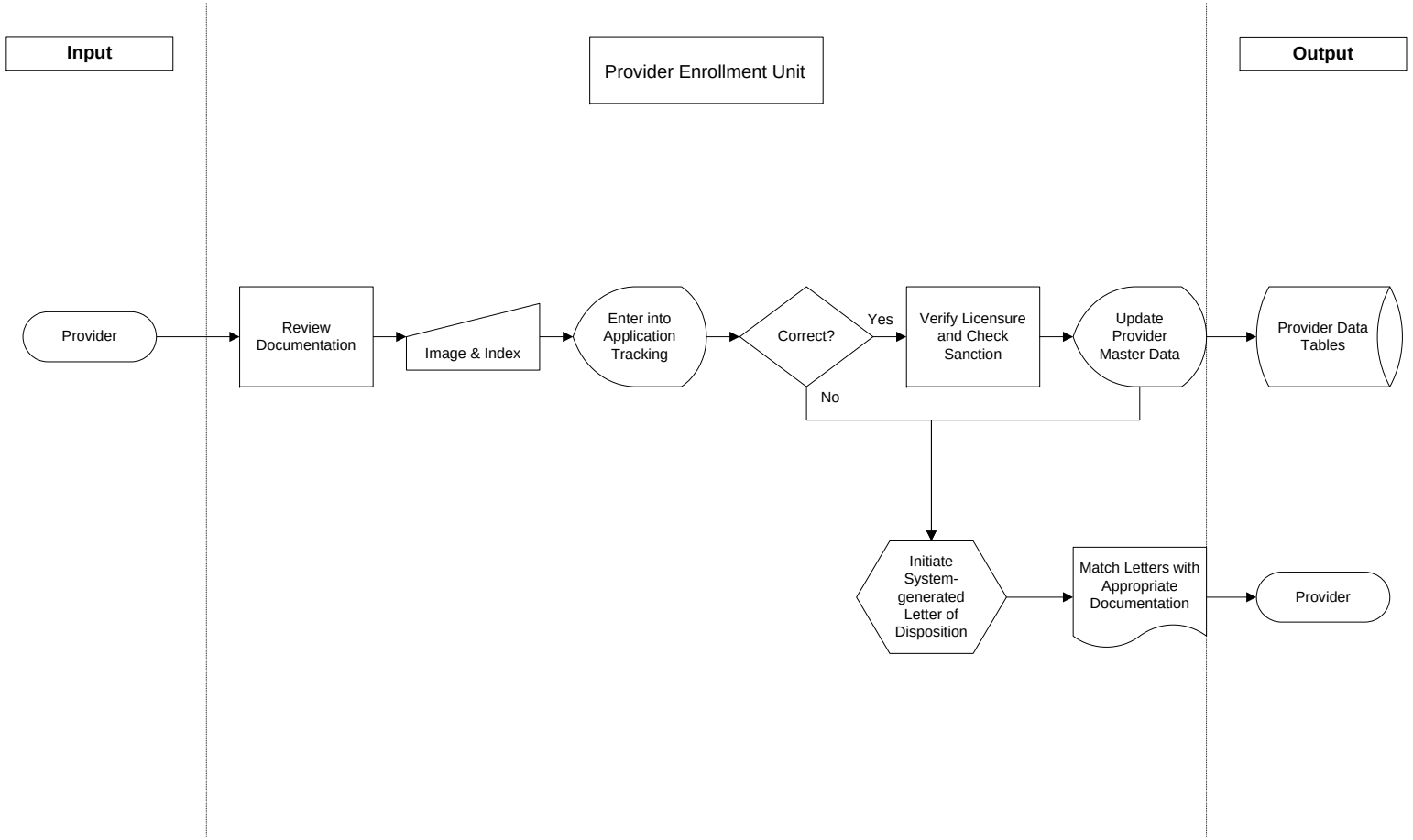
The provider may resubmit an application, but must include all requirements for enrollment. Any sort of manual corrections (white out, cross-through, etc) is not permitted on the preprinted area of the agreement and application.

First Health has specific guidelines for meeting DMAS enrollment requirements:

For this transaction…	No more than…
Initial Enrollment	15 Business Days
Re-submittals	5 Business Days
Change Request	15 Business Days
Cancel Request	15 Business Days
Re-certifications	15 Business Days
Correspondence	15 Business Days
Medallion	3 Business Days
Nursing Home	10 Business Days

WORKFLOW PROCESS

Provider Enrollment Procedures: Enroll Providers



4.1 Review the Provider Application

Applications received by PEU are reviewed by the Provider Representatives for content and completeness. The documents must pass the review before they are entered into the Provider Database. Once the documents pass the initial review, you will search the provider database to determine the validity of the application based on DMAS enrollment requirements.

Procedure

1. Verify that the documents have been imaged and profiled. If the application fails this requirementt, return the batch or packet to the Document Control Clerk.
2. Use the application check-list below to evaluate the application for suitability and completeness. All Required fields must be Y (Yes) for the application to be carried forward. Follow the directions for the Conditional status items.

Status	Item to check	Y	N
Required	Is the application completely legible, signed and dated?	Y	N
Required	Is the applicant applying for Initial Enrollment or a change to an existing enrollment?		
Required	If an individual application for a group-eligible provider type is received with an attached ROB, PEU will search for a billing group under the Type 2 NPI shown on the ROB. • • If a group is found, the individual provider is enrolled and then associated to the group. • • If a group is not found and the FEIN given on the application hits the share FEIN edit, the individual application is rejected with Reject Reason **Shared FEINs must formulate a Billing Group**. If an individual application for a group-eligible provider type is received without an attached ROB, the individual provider is entered into Application Tracking. • • If the FEIN submitted for the Type 1 NPI, the application is approved. • • If the FEIN is not unique for a Type 1 NPI, the application is rejected with Reject Reason Shared **FEINs must formulate a Billing Group**.		
	• • When the group application is submitted, the group is enrolled and all providers listed on the roster form are associated to the group.		
	If any individual has the same FEIN on their Type 1 NPI Billing Information as the group FEIN, the Type 1 Billing Information FEIN is blanked out so that the provider can only bill as a group servicing		

Status	Item to check	Y	N
	provider. If the individual has an SSN or unique FEIN on their Type 1 NPI Billing Information, it is left in place so the provider can bill either with the individual EIN as his own billing provider or as a servicing provider under the group.		
Conditional	The License, Certification, JCAHO Certification, Medicare Certification, Business License, Pharmacy permit, etc. is attached. The license must be verified through Internet sites such as CMS and DHP or the provider's licensing state.	Y	N
Conditional	The license dates cover the application date requirements.	Y	N
Required	The required Participation Agreement and HIPAA Privacy Agreement are attached	Y	N
Conditional	The provider has attached the Ambulance Agreement Required for transportation provider types 080, 082, 083, 084.	Y	N
Conditional	Does the provider application meet the In-State Provider requirements? Review the Address to determine if the provider meets the 50 mile radius criteria to be enrolled as an in-state provider; however, their licensure is not verified through the State of Virginia DHP (Department of Health Professionals). An exception to the licensing requirement may apply to Pharmacy providers. If the provider's servicing address is not in Virginia, check the list of cities that fall within 50 miles of the border or use the Internet tool MAP QUEST to determine if the applicant meets the 50 mile requirement. Applicants that meet the 50 mile requirement can be enrolled with the appropriate in state provider type. The application must be completed as enrolling as an in-state provider.	Y	N
Required	The application indicates the type of program in which the provider wishes to participate. The provider must enroll in the Medicaid Program (01) before enrolling in programs 02, 03, 04, 05, - 06 (TDO) and 08 FAMIS) is the exception. If 06 - TDO only, Provider Type – 100.	Y	N
Optional	The provider has chosen to participate in the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Specialty Type - 035.	Y	N
Required	The applicant's Legal Business Name or Individual Name is on the application.	Y	N
Conditional	The specialty certification dates cover the application date requirements (if applicable).	Y	N
Conditional	Prescribing providers must have the DEA number on the application and the license must cover the application dates.	Y	N
Required	The IRS Name on the application is the same as the IRS Name on the	Y	N

Status	Item to check	Y	N
	W-9 form if attached.		
Required	At least one of the following is required: the TIN (Tax Identification Number), SSN and/or EIN.	Y	N
Required	The applicant has marked the **Type Of Applican**	Y	N
Conditional	The provider has provided the Fiscal Year Date. Required for specific provider types; 01, 02, 04, 06, 08, 10, 11, 12, 14, 15, 16, 17, 18, 19, 28, 29, 52, 53, 85.	Y	N
Conditional	The application has provided the full legal name of the administrator. Required for specific Provider Types (001 thru 019, 028, 029, 091, 092).	Y	N
Conditional	The number of NF beds a provider has, based on the Bed Type. Required for provider types - 06, 10, 11, 15, 16, 17, 18, 28 and 29. Must equal the sum of Beds NF, Beds SNF/NF, Beds SNF, Non-Certified Beds and Beds ICF-MR.	Y	N
Conditional	The Provider is eligible to provide Case Management services.	Y	N
Required	The provider has indicated the location of where the Provider Enrollment notifications are to be mailed.	Y	N
Required	The application indicates the complete servicing address-NOT a Post Office box number. If the servicing address does not receive mail, the **Mail To** address can be a PO Box.	Y	N
Required	The application indicates a complete servicing telephone number with area code on the application.	Y	N
Conditional	There is a complete 24 hour telephone number with area codes when the provider is applying a Managed Care program(s).	Y	N
Optional	The provider has specified an address as a **Mail To** address. Provider Manual, Provider Manual Updates, Provider Enrollment notifications, EMC/ERA notification etc., will be mailed to the servicing address.	Y	N
Optional	The provider has indicated an address for the **Pay To** address. If no **Pay To** address and no ERA Agreement on file is provided the provider check will be mailed to the Servicing Address if no **Mail To** address is provided.	Y	N
Optional	The provider enrolling in a Managed Care program – 02, 05, indicates the desire to be affiliated with other providers enrolled in the Medicaid program and has listed the provider(s) name and provider ID.	Y	N
Optional	The Signature Waiver Request is indicated.	Y	N
Required	The application is signed and dated by the provider or an authorized person.	Y	N

Status	Item to check	Y	N
Required	If the provider is considered a Healthcare Service Provider (Typical), the provider must submit their NPI on the provider application.	Y	N

3. Are items missing from the application? Follow procedures to inform the provider what is needed to complete the application process. A **Reject** letter is to be requested through the Automated Mailing application.
4. If the Application is approved, enter an **Application Tracking** record with an applicable Reason Code and enter the Tracking Number the Application.

4.2 Check the Applicant's Current Status

When the Provider application has been validated and approved for enrollment, you must check the applicant's current status using DMAS guideline's for new provider enrollment.

Procedure

From the VaMMIS VA DMAS Main System Menu (RF-S-010):

1. Choose the **Provider** icon and the **Provider Main Menu** is displayed
2. Select a value from the **Provider Cross Reference Inquiry** drop-menu.
3. Select the **Inquiry** radio button.
4. Enter the value to search for (NPI, API, EIN, Provider Name, etc.) in the **ID Value** field.
5. Choose **Enter**.
6. The **Provider Cross Reference** screen (PS-S-012) is displayed.
7. Use the question and response grid to evaluate the provider's eligibility to enroll.

Question	Yes	No	Follow-on Question	Response
Is the Provider enrolled in a DMAS program?		✓		You can enroll the provider. Continue by following the instructions in Section 4.3 to check the Provider's Exclusion/Sanction status.
	✓		Is the provider enrolling for another office location?	If the provider wants to enroll under multiple office locations, you can enroll the Provider. Continue by following the instructions in Section 4.3.
	✓		Is the provider using a new tax ID?	If the provider wants to enroll using a new tax ID and maintain enrollment under the current one, you can enroll the Provider.

Question	Yes	No	Follow-on Question	Response
	✓		Is the provider using a new Provider type?	If the provider is enrolling with a new provider type in the current location, you can enroll the provider.
	✓		Is the provider practicing in a facility under new ownership?	If the provider is practicing at a facility under new ownership, enroll the provider.
	✓		Is the provider already enrolled at the same location, with same FEIN?	Reject the application and inform the provider of the number previously assigned for the current location and FEIN.

4.3 Check Provider Sanction/Exclusion

First Health Services Corporation's Provider Enrollment Unit (PEU), functioning as an agent for Virginia's Medical Assistance Program, verifies that all individuals and entities requesting initial enrollment or reinstatement as a provider of services to the Virginia Medical Assistance Program (VMAP) have not been excluded from participation in federally-funded health care programs.

If the Provider's application can be processed and the provider meets all DMAS program-enrollment criteria, you must check the Provider for any sanctions on the List of Excluded Individuals/Entities (LEIE). As part of the MMIS screen processing, the MMIS automatically compares provider data (for individual Providers--last name and SSN, for a business--the business name and FEIN) against the LEIE maintained by HHS (Office of Inspector General).

PEU group members will use the functionality to check for sanctions when adding, reinstating, recertifying, or changing Provider information. The MMIS does this automated query after completion of information on screen PS-S-001-02. PEU will match the Provider against this LEIE when attempting to initially enroll, to recertify, or to reinstate providers in the VaMMIS or when changing data on the Provider record. The steps below outline the automated sanction-check process and followup steps to take based on the result of the check:

Procedure

1. Complete all data requested on screen PS-S-001-02 (Provider last name and SSN or business name and FEIN).
2. Choose **Enter**.
3. The provider sanction edit will query the internal List of Excluded Individuals/Entities (LEIE) database.

4. Depending on the query result, you see a message or a new screen. Is there a Provider match against the LEIE database?

   No! You see a message at the buttom of the screen PS-S-001-01 **NO SANCTION DATA**.

   1. List the date verified and your initials on the batch cover page and continue processing.

   Yes! The query returns a possible match. You still have to verify that it is the exact match for the provider you are working with. Do this:

   1. You see the Provider Sanction Search screen (PS-S-160) with sanction data that may match the Provider you are processing.

      Note: For a detailed description of the Provider Sanction Search screen and the data on it, see the on-line HELP system or the Provider Subsystem User Manual. An illustration of the screen sequence follows this section.

   2. Look at the data to determine if the listing matches one or more of the provider's attributes:
      - Exact match of first and last name
      - Exact match of social security number
      - Exact match of FEIN

      Note: if necessary, you can view the complete sanction record by choosing a record on the Provider Sanction Search screen (PS-S-160) and choosing Enter. You see a detailed record of the sanction on the Provider Sanction Search Detail screen (PS-S-161).

5. Do you have an exact match?

   No! If the sanction data does not match against the Provider's data for any of these attributes, do this:

   1. Choose the Accept button on the Provider Sanction Search screen (PS-S-160).
   2. List the date verified and your processor's initials on the batch cover page.
   3. Continue processing the Provider application.

   Yes! If the sanction data does match one or more of the attributes, do this:

   1. Choose the **Reject** button on **Provider Sanction Search** screen (PS-S-160).
   2. Do not continue processing.
   3. Tell the PEU Supervisor about the potential Provider sanction.

6. The PEU Supervisor will review of all respective data to determine the accuracy of the match. If the match is inaccurate, the PEU Representative can continue processing the enrollment application or request. If the match is accurate, do this:

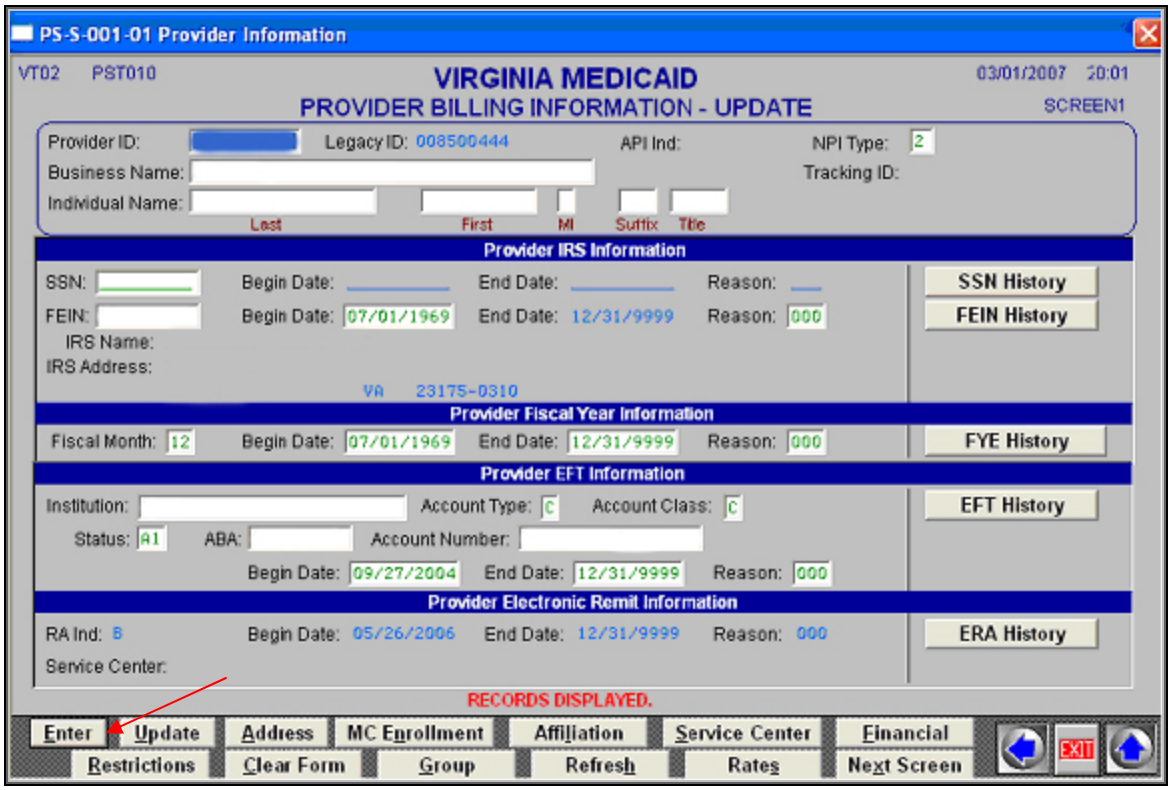
   ❖ Prepare a package of these items:
   - the OIG exclusion information
   - the enrollment application or request

- any other associated documentation

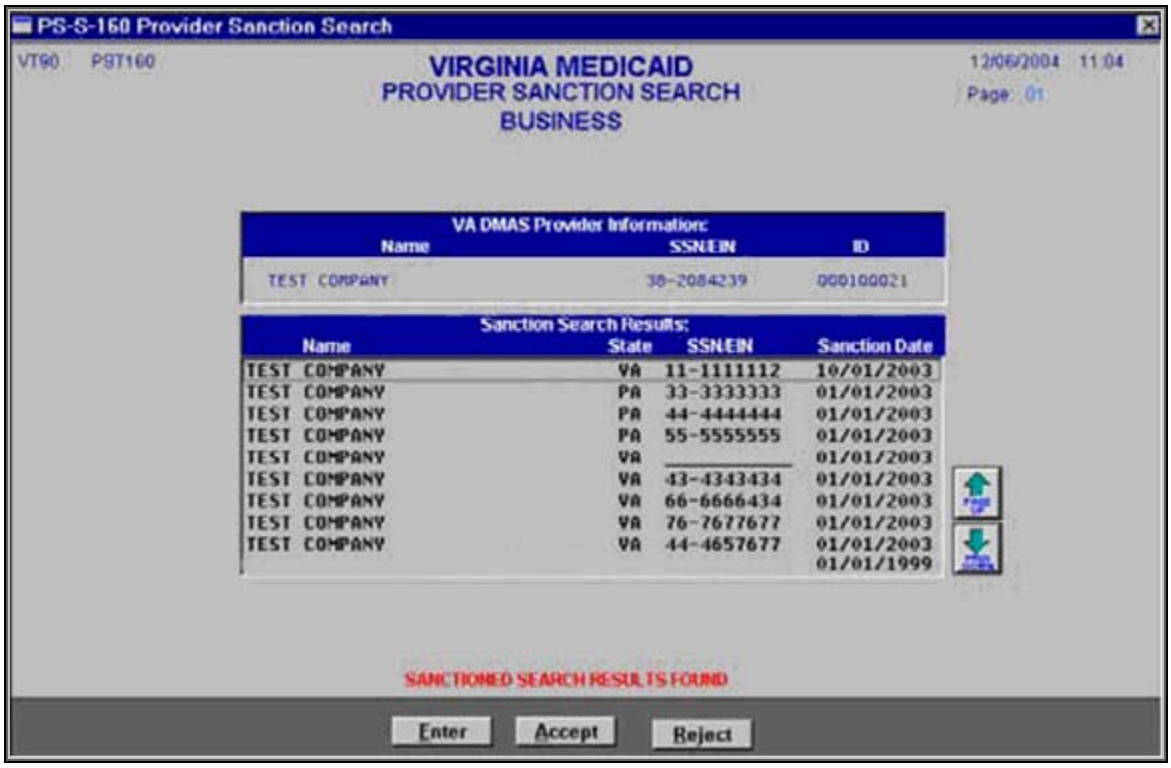
❖ Forward the package via inter-office mail to the DMAS Provider Enrollment Contract Monitor for final determination and/or course of action.

Screen Sequence for Provider Sanction Query

1. Choose **Enter** to begin the Provider sanction query.



2. If the query returns a possible match, you see the **Provider Sanction Search** screen (PS-S-160).



3. Choose a record to see the details.

4.4 Verify Licensing Requirements

Each Provider must be reviewed for license requirements. Every license must be verified either by DHP (In-State) or by a licensing entity specific to the state and provider type.

Note: You must also verify that the Provider's licensure dates fall within the dates requested on the enrollment form as program begin dates.

Type	Name
044	Audiologist
034	Certified Nurse Specialist
035	Certified Registered Nurse Midwife
026	Chiropractor
025	Clinical Psychologist
040	Dentist
062	Durable Medical Equipment
076	Licensed Clinical Social Worker
021	Licensed Professional Counselor
023	Nurse Practitioner
031	Optometrists
060	Pharmacy
020	Physician/Psychiatrist
030	Podiatrist
102	Marriage & Family Therapist

Procedures

Search By License Number Or Name For Providers Licensed By The Department Of Health Professions

1. From your desktop, log onto the internet web site www.dhp.state.va.us
2. Choose the **License Number** field or **Name** field.
3. Type in the license number or name you want searched.
4. If on the database, you see a record returned.
5. Verify this is the same provider or see the next provider meeting the criteria you specified.

6. If there are no Proceedings for the provider, the license is valid and the provider is not on the excluded list.

Index the DHP Verification

1. If the Provider has a proceeding of **YES**, copy the screen to PCDocs
2. Choose the **Print Screen** key to copy the screen on the clipboard if the license is not attached.
3. Open a Word document by clicking new on the toolbar in MS Word.
4. Place the cursor in the body of the document by selecting the screen using your mouse.
5. Press **CTRL + V** to paste the DHP screen into the Word document.
6. Choose **File**, **Save As**.
7. You see the PCDOCs profile box.
8. Enter the provider's number which you just assigned or re-certified.
9. Enter the provider's name. Last name first, then first name and middle initial.
10. Enter the document type. It should be **LI** for license.
11. Enter the document name as **LI**.
12. Choose the **Enter** key or choose **OK**.
13. Select the picture and delete the print if you need to make another Index item.

4.5 Complete Screens to Enroll a Provider

If the Provider's application can be processed and the provider meets all the requirements outlined in the preceeding sections, complete the screens listed below for each provider to be enrolled. Follow the instructions for each field on the screen using the field-by-field instructions in the screen completion grids or on-line HELP system.

Procedure

From the VaMMIS Main System Menu (RF-S-010):

1. Choose the **Provider** icon.
2. You see the **Provider Main Menu** screen (PS-S-000).
3. Choose the **Add** radio button.
4. Complete the screens listed in the grid as specified in the **Notes** field.

Screen Number	Screen Name	Notes
PS-S-071 PS-S-072 PS-S-073 PS-S-074	Application Tracking	Follow the instructions for each field on the screen using the field-by-field grid in the user manual or on-line HELP system.
PS-S-001-01 PS-S-001-02 PS-S-001-03 PS-S-001-04 PS-S-001-05	Provider Information	Follow the instructions for each field on the screen using the field-by-field grid in the user manual or on-line HELP system.
PS-S-022-01 PS-S-022-02	Provider Address Screens	Required ONLY if the provider wants the Correspondence, Pay- To- Address, and/or the Remittance Advice to be different than the Servicing/Physical Address. Follow the instructions for each field on the screen using the field-by-field grid in the user manual or on-line HELP system.
PS-S-023	Managed Care Affiliation	Required only if the Provider wants to be affiliated with another providers and is enrolled in Program 02 (Medallion) and/or 05 (CMM) with Begin and End Dates for each Provider. Follow the instructions for each field on the screen using the field-by-field grid in the user manual or on-line HELP system.
PS-S-015	Medicare Cross-Reference	Optional – If the provider is participating in the Medicare Part A or Part B. This allows the crossover claims to be paid without submitting a Title XVIII. Follow the instructions for each field on the screen using the field-by-field grid in the user manual or on-line HELP system.
PS-S-030	CLIA Update	Conditional – Required for Provider 70 Laboratory. Optional for all other provider types. A CLIA number be on file for laboratory services to be paid except for CLIA Waived Test. Follow the instructions for each field on the screen using the field-by-field grid in the user manual or on-line HELP system.
PS-S-005 PS-S-006	Provider/Group Group/Provider	Follow the instructions for each field on the screen using the field-by-field grid in the user manual or on-line HELP system.
PS-S-010	Provider Restriction	Used to define authorized services for Mental Health Mental

Screen Number	Screen Name	Notes
	Update	Retardation (PCT 056) provider. Follow the instructions for each field on the screen using the field-by-field grid in the user manual or on-line HELP system.
PS-S-007-01		This screen is allows authorized personnel to Add or Update on the Individual Provider Rates. This screen required to maintained for provider types; 1-19, 27, 28, 29, 52, 53, 57, 85, and 91.
PS-S-007-02		This screen is allows authorized personnel to add and update Provider Type Rates.
PS-S-007-03		This screen is allows authorized personnel to add or update the provider rates.

4.6 Evaluate the Provider Application for EDI/EFT/POS Registration

To finish processing the application, see if the provider wants to enroll in the EDI/EFT/POS electronic data interchange programs. If the proper documents are attached to the provider application, you can process the provider's request. All EFT requests are processed by the EFT Coordinator. All EDI requests are processed by the EDI Coordinator.

Procedure

1. If the Provider is applying as a Point of Sale provider, is an electronic POS application included and does it meet all these criteria? If yes, enter the POS required information.
2. If an EDI/ERA registration form included in the enrollment package, forward the EDI registration application to the EDI coordinator.
3. If an EFT registration form included in the enrollment package, enroll the Provider then deliver the EFT Agreement to the EFT Coordinator.

4.7 Finalize Batch Review and Quality Control

Upon completion of a batch of documents the reviewers initials and date are written in the space provided on the Batch Contol Sheet and the batch is placed in the basket of completed batches

Procedure

1. Initial and date the batch in the **Representative Completion** field on the Batch Control Sheet.

2. Place the batch in the **Completed Batches** basket
3. The batch is reviewed by Quality Control Review for each process: change request, termination, EFT, DHP verification, letters, etc. If the batch is complete, the batch is stored for three (3) months.
4. If the batch is incomplete, the batch is returned to the Provider Enrollment Representative for corrections.

5.0 Maintain the Provider Database

The provider application information and provider checklist information are entered on the Va DMAS Provider database. The Application Tracking screen tracks the provider's application for enrollment from receipt to final disposition.

The provider application and the provider information checklist are needed to complete the provider enrollment process. The Provider Information process is a series of five On-line screens providing the capability to add a record on the Provider database. Inputs include the Provider application indicating the type of Medicaid program(s).

**********Not currently in use**********04/24/03

The provider checklist will determine if all necessary information is present to complete the provider enrollment process. You may not have all of the appropriate data that is needed to enter the complete enrollment process. Enter zeros in the field(s) of missing/incorrect data using the Begin Date and End Date (if applicable) as if you are approving the application with appropriate Reason Code - Example 021- Additional Information Needed, 030 - DHP License has expired.

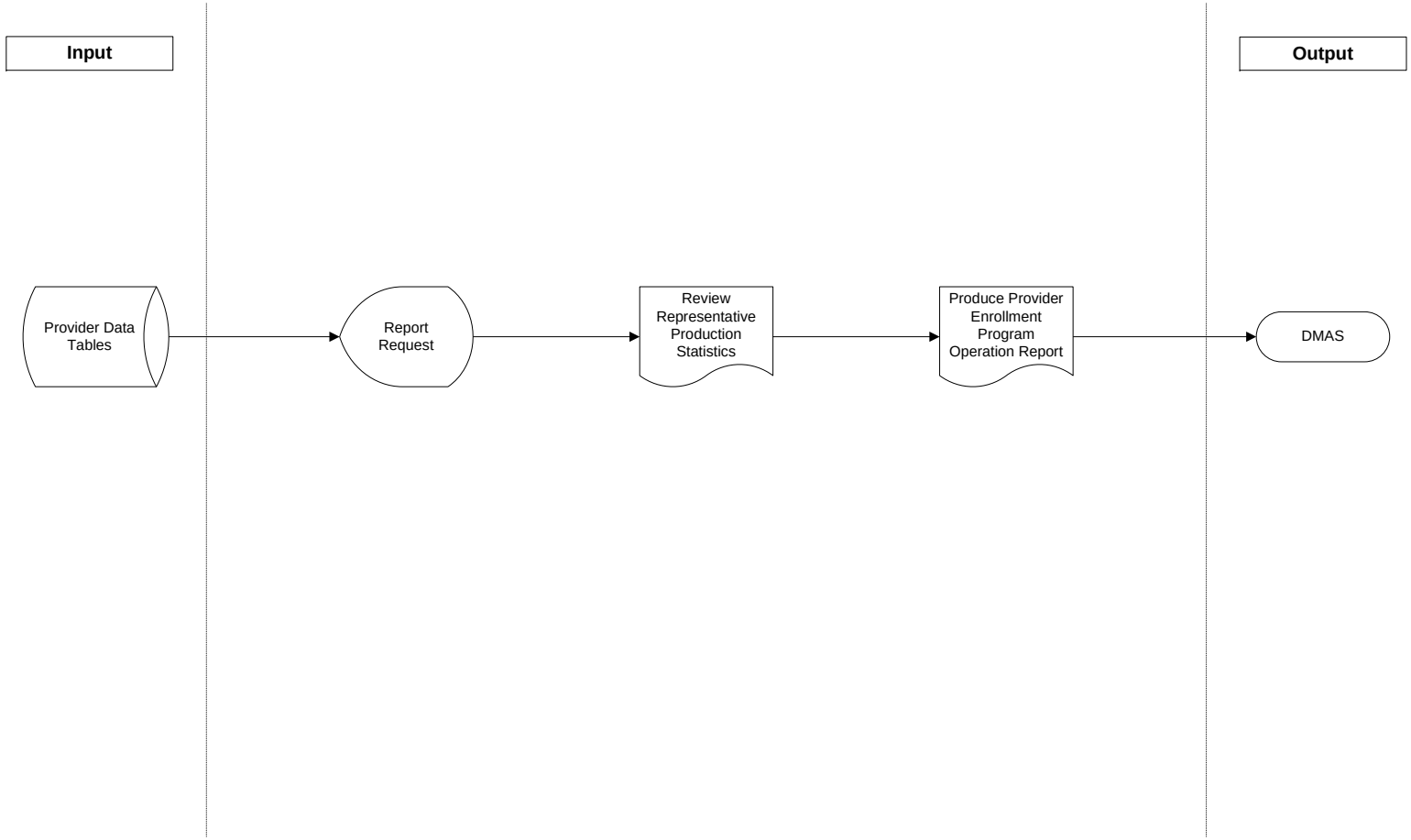
Regardless of the Provider Application Status, this process is necessary to create a letter informing the provider of Approval – Provider ID and Effective Date. If the application is Pended,or Denied- the system will generate a letter of status indicating the reason(s) and instructions of resubmittal (if applicable).

**********04/24/03

If the application is not approved, return the enrollment packet to the provider using an explanatory letter available in the PEU directory.

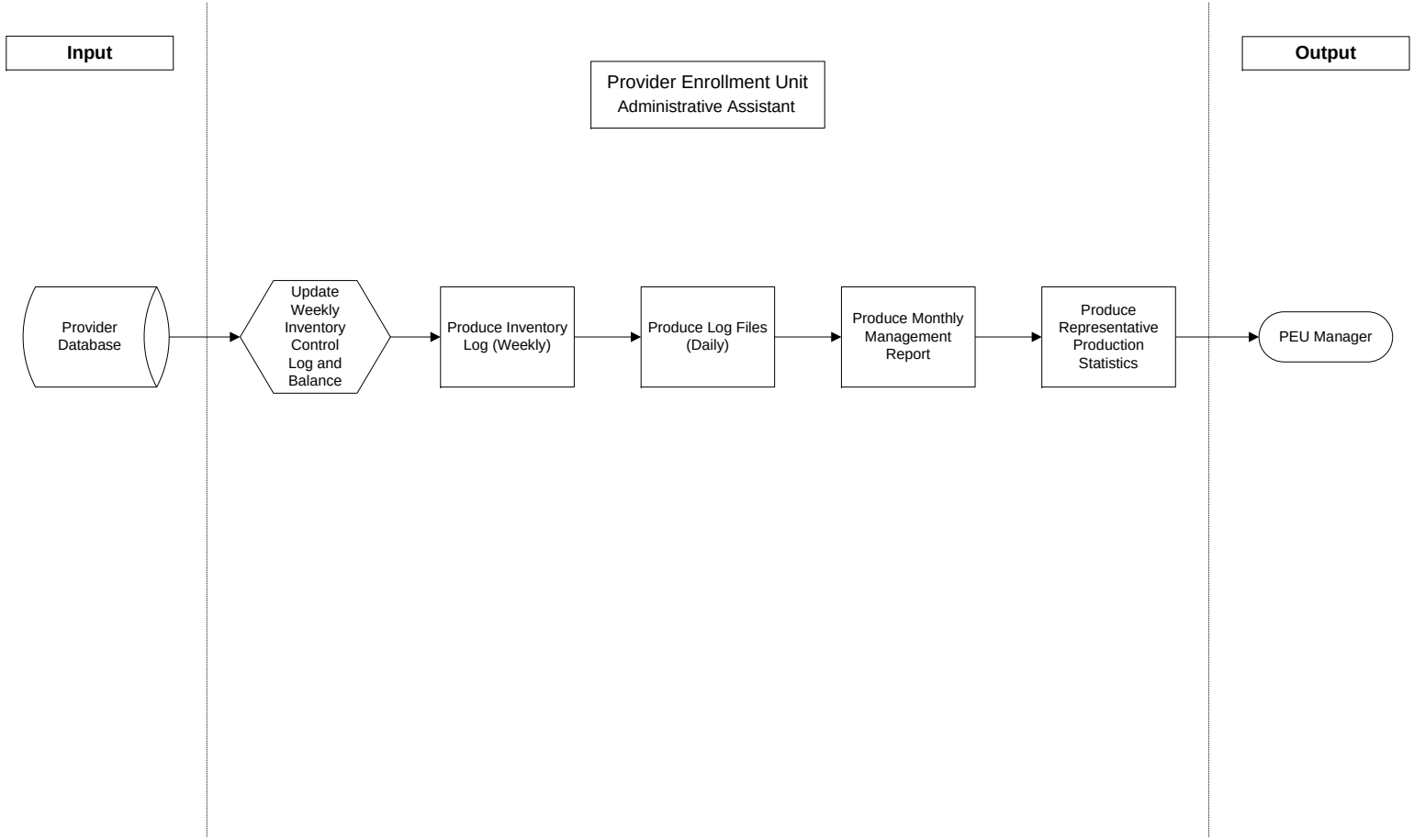
WORKFLOW PROCESS

Provider Enrollment Procedures: Maintain Provider Database



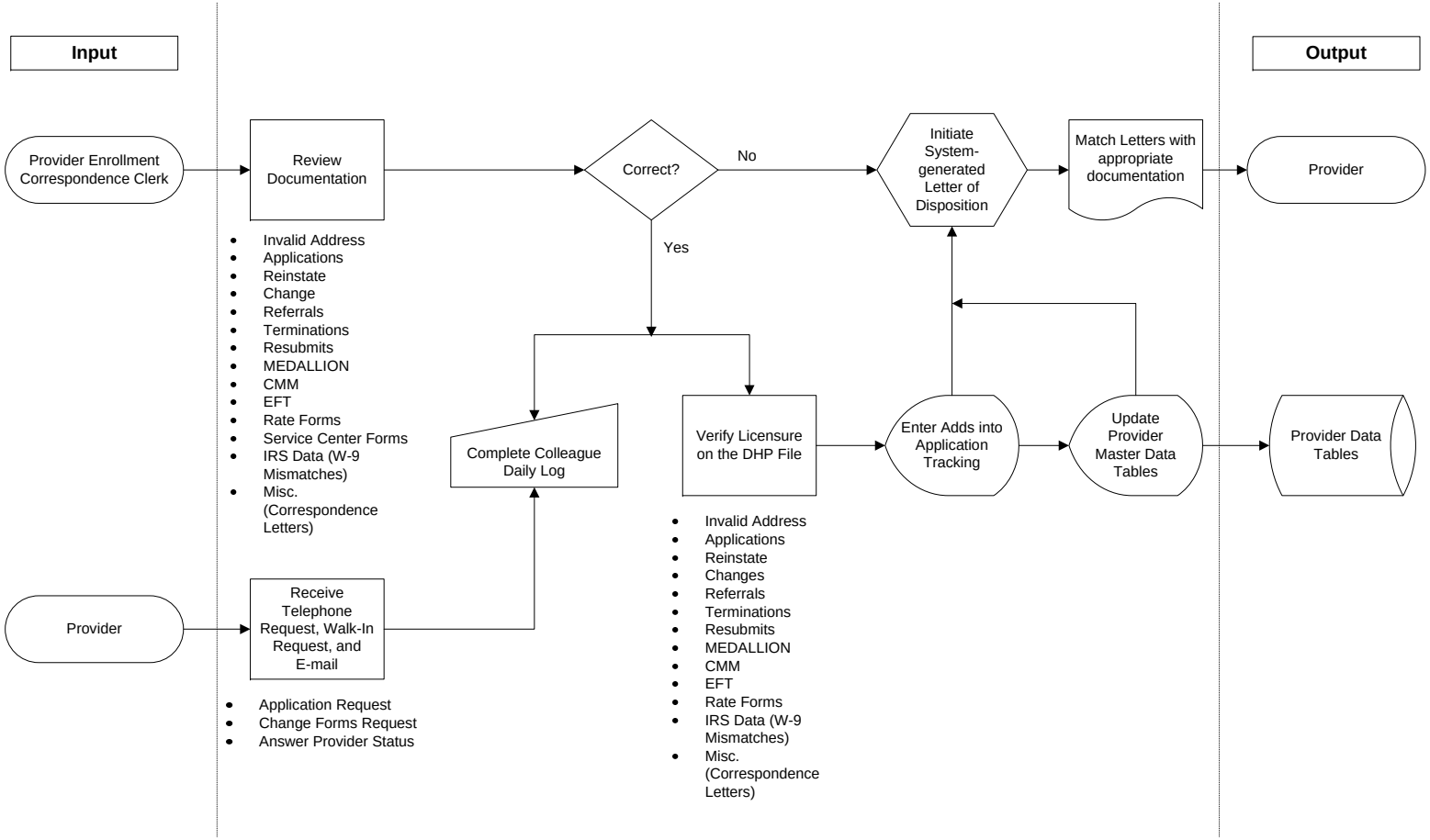
WORKFLOW PROCESS

Provider Enrollment Procedures: Maintain Provider Database



WORKFLOW PROCESS

Provider Enrollment Procedures: Maintain Provider Master File



Provider Enrollment Screen Completion Grid

Complete the screens listed below for each provider to be enrolled. Complete the screens listed in number one **Enrollment** first, then complete the other screens that are needed, depending on the answers to the **Add On** questions. For details on specific screen navigation and field entries, or specific data elements, follow the instructions in the user manual or On-line HELP system.

For this:	Complete Screens…	Add-on Question	Yes	No
1. Enrollment	Application Tracking PS-S-002 Provider Information PS-S-001-01 PS-S-001-02 PS-S-001-03 PS-S-001-04 PS-S-001-05			
2.		Is the Provider Requesting that the Mail –To Address, Pay-To-Address, and/or the Remittance Advice to be different from the Servicing/Physical Address?	Complete screen PS-S-022 Provider Address	Go to Question 3.
3.		Is the Provider enrolled in Program 02 (Medallion) and/or 05 (CMM) Request to be affiliated with other providers? Are there Begin and End Dates for each Provider?	Complete Screen PS-S-23 Managed Care Affiliation	Go to Question 4.

For this:	Complete Screens…	Add-on Question	Yes	No
4.		Is the Provider Participating in Medicare Part A or Part B? (This information allows the crossover claims to be paid without submitting a Title XVIII form.)	Complete screen PS-S-15 Medicare	Go to Question 5.
5.		Did the Provider indicate a CLIA number? (Required for Provider Type 70, Laboratory) This is optional for all other provider types. A CLIA number must be on file for laboratory services to be paid, except for CLIA Waived Test.	Complete screen PS-S-030 CLIA	Go to Question 6.
6.		Is the Provider a Cost Settlement Provider? Specifically a provider type 01, 02, 04, 06, 08, 10, 12, 14, 15, 16, 17, 18, 19, 28, 29, 52, 53, 77, or 85?	Complete screen PS-S-007-01 Individual Rates	Go to Question 7.
7.		Is the Provider to be enrolled in a group?	Complete screen PS-S-005 Provider/Group	End of Process.

5.1 Enter Provider Enrollment Tracking Data

Enter provider application information and provider checklist information to the VaMMIS Provider database. For Healthcare Services Providers, the NPI is entered as the Provider ID. For Atypical Services Providers, the system automatically generates a new Atypical provider number when all the required information is entered. The Application Tracking screen tracks the provider's application for enrollment from receipt to final disposition (approval or denial). There must be an entry for each program code in which the provider is participating. The provider must be enrolled in the Medicaid program (01) to participate in Program Codes 02, 03, 04, 05, 07 and 08 – exception is TDO (Temporary Detention Order - 06). This screen must be completed if the provider application status is approved before entering all other provider information.

Procedure

From the VaMMIS Main System Menu:

1. Select the **Provider** icon and the **Main Menu** screen is displayed
2. Select **Application Tracking** from the drop-menu in the **Selection** field.
3. Choose the **Add** or **Update** radio button in the **Function** field.
4. In the **ID Value** field:
    - ❖ When you add a Provider: Leave the ID Value field blank. The system generates a Provider ID on the Application Tracking Screen.
    - ❖ When you Update a Provider: Enter the Provider Identification Number.
5. The **Application Tracking** screen (PS-S-002) is displayed.
6. After entering data for an Update, choose **Enter**. If no errors occur, choose **Update** to save the record. If error messages appear on the bottom of the screen, make correction(s), choose **Enter**. When no error messages appear, choose **Update** save the data.
7. Choose the **Prov Info** button to proceed to the **Provider Information** screen.
8. Write the new Provider ID on the Provider Information sheet.

Note: There may be many entries for one application number. When the application is approved, a new entry line will be created on the screen for each Program Code and the Begin and End date will be the same.

5.2 Enter Provider Enrollment Information

The provider application and the provider information checklist is needed to complete the provider enrollment process. To complete the provider enrollment information process, you will use a series of five related screens. When complete, the record will be added to the Provider database. You will use the Provider application that indicates the type of Medicaid program(s).

The provider checklist determines if all necessary information is present to complete the provider enrollment process. You may not not have all of the appropriate data that is needed to enter the complete the enrollment process. Enter zeros in the field(s) of missing/incorrect data using the Begin Date and End Date (if applicable) as if you are approving the application with the appropriate Reason Code.

Examples	
Reason Code	**Description**
021	Additional Information Needed
030	DHP License has Expired

Regardless of the Provider Application Status, this process creates a letter informing the provider of Approval based on Provider ID and Effective Date. If the application is Pended, Rejected or Denied, the system will generate a status letter indicating the reason(s) and instructions of resubmittal (if applicable).

Procedure

1. Choose the **Provider** icon.
2. You see the **Provider Main Menu** screen (PS-S-000).
3. Choose **Provider Information** from the drop-menu in the **Selection** field, choose **Add** in the **Function** field and click the **Enter** radio button.
4. You see the **Provider Application Tracking Menu** screen (PS-S-071).
5. Choose **Application Tracking Add/Update** from the **Selection** field.
6. Choose the **Add** radio button in the **Function** field.
7. Click the **Enter** radio button.
8. You see the **Provider Application Add/Update** screen (PS-S-073).
9. Enter the required data.
10. Click the **Enter** radio button.
11. Click the **Update** radio button.

12. Click the **Status** radio button.
13. If the application is approved, place an **A** in the **Status** field and click the **Provider Info** radio button.
14. You see the **Provider Billing Information – Update** screen (PS-S-001-01).

For field instructions for each screen associated with PS-S-001-01, see the Provider Enrollment Field Completion Grid for PS-S-001 in Appendix A.

Note: You may navigate from the Provider Application Screen; after adding or updating the Provider Application Status information; to the Provider Information Screen by choosing the Prov Info button.

To complete the Provider Information, enter the information and choose Enter to edit the data for each of the five screens. If error(s) appear, make the correction(s), choose Enter. If all edits are passed, choose the Next Screen button; repeat the process for the next three screens. All required data elements must be entered and pass all edits for the enrollment add or Update. Choose Update on PS-S-001-4 to post the provider information to the Provider database. Then, proceed to any other applicable screens to complete the enrollment.

In Update mode, if data is added or changed on a screen, you must choose the Enter button. The Enter button edits the data on the screen for correctness and displays the appropriate error message when necessary. If no data is changed or added on a screen, choose enter. You see this message: **Data Not Changed**. Then, choose the Next Screen button, continue the process until all five screens have passed through each screen edits, choose Update to post the data to the Provider database.

5.3 Enter Provider Address Data

For an initial enrollment, the address data is entered on the Provider Application Add/Update screen. (PS-S-073) A valid servicing address is required; Post Office box addresses are not acceptable. The application will be returned to the provider if submitted with a post office box address as the servicing address. .After the provider is added to the provider database, different Mail to, Pay to, and Remittance Advice address(es) may be added to the provider database.

- **Mail-to Address:** A Post Office address is acceptable for the Mail-to address. The Mail-to address is the address to which the provider wants all other Medicaid-related correspondence sent. If this line is left blank, correspondence will be sent to the servicing address. Group members that use the locations of their groups as their correspondence address receive Re-assignment of Benefits application, welcome letters, and provider handbooks at the group practice addresses. Groups that ask their members to have all

correspondence sent to the group addresses are responsible for passing all correspondence to the group members.

- **Pay-To Address:** This is the address to which the provider wants the Medicaid payment (check) sent. If there is no entry, the provider checks will be sent to the provider's Servicing Address.
- **Remittance Advice Address:** This is the address where the provider wants Medicaid payment information (remittance advice) sent. If there is no entry, the remittance vouchers will be sent to the Pay-To address. If there is no entry in the Pay- to Address, Remittance Advice will be mailed to the Mail-to Address. If there is no entry in the Mail-to Address the Remittance Advice will be mailed to the Servicing Address.

Electronic Remittance Advice

The provider may want the Remittance Advice sent electronically. If so, the Provider must complete an Electronic Remittance Advice Application. The EDI Team handles this function. Forward the EDI information to the EDI coordinator.

Note: Refer to the US Postal Guidelines for correct address formatting.

Procedure

From the VaMMIS Main System Menu:

1. Choose the **Provider** icon.
2. You see the **Provider Main Menu** screen (PS-S-000).
3. Choose **Billing Addresses** or **Service Address** from the drop-menu in the **Selection** field.
4. Choose the **Add** or **Change** radio button in the **Function** field.
5. Enter the Provider NPI or API Number in the **ID Value** field.
6. Choose **Enter**.
7. You see the **Billing Addresses – Update** (PS-S-022-02) or **Servicing Address** (PS-S-022-01) screen.

For more details on specific screen navigation and field entries, or specific data elements, refer to the On-line Provider Subsystem User Manual, and/or the On-line HELP system.

5.4 Enter Provider Change Data

All providers enrolled in the Medicaid Program must adhere to the conditions of participation outlined in their provider agreement. Providers approved for participation in the Medical

Assistance Program must immediately notify the Provider Enrollment/Certification Unit at First Health in writing of any change in the information that the provider previously submitted.

The provider may request certain information to be changed on the provider database. A change to the Provider Type may not be requested by the provider. The provider must submit a new application with all supporting documentation. All changes must be requested in writing. The letter must contain the date of request, the Provider ID, Name, Effective Date, and an actual provider signature and/or authorized signature.

Note: All Medallion, Cost Settlement Providers, Tax Group, EFT, and Change of Ownership (CHOW) changes can only be changed by authorized personnel. If the provider is requesting a TIN (Tax Identification Number - SSN/FEIN) to be changed at the same location, this action can take place. The provider must submit a new application if moving to a new practice. The providers in the table following the procedures must be enrolled by a supervisor.

Procedure

From the VaMMIS Main System Menu:

1. Choose the **Provider** icon.
2. You see the **Provider Main Menu** screen (PS-S-000).
3. Choose the appropriate screen for the change.
4. Choose the **Update** radio button in the **Function** field.
5. Enter the Provider NPI or API Number in the **ID Value** field.
6. Choose **Enter** to display the record.

Provider Type	Program Codes
Medallion I	02
Medallion II	03
Options	04
CMM	05
FAMIS	08

5.5 Enter Provider Cancel Data

A provider may end participation in one or more Virginia DMAS programs at any time. To do this, the provider must make a written termination request to the Provider Enrollment Unit. The request must be on letterhead paper and must identify Provider servicing name, servicing address, ID, program cancellation request, and effective cancellation date. If Program 01

(Medicaid) is cancelled, all other all programs will also be cancelled--except Program 06 (TDO).

The cancel date may be in the past, or be current or a future date. A cancel letter will be generated when the Provider is cancelled. This letter informs the provider of the cancellation in the specific and/or all Medicaid programs and includes a reason and the date of the cancellation.

Procedure

From the VaMMIS Main System Menu:

1. Choose the **Provider** icon.
2. You see the **Provider** Main Menu screen (PS-S-000).
3. Select **Provider Cancel** from the drop-menu in the **Selection** field.
4. Choose the **Update** radio button in the **Function** field.
5. Enter the Provider Identification Number in the **ID Value** field.
6. If no entry is made in the **ID** field, enter the Provider ID number on the **Cancel** screen.
7. Choose **Enter**.
8. You see the **Provider Cancel/Un-Cancel** screen (PS-S-004).
9. To cancel the program(s) of a provider, type over the **End Date** of the record(s), and choose **Enter**.
10. After entering data for an **Update**, choose **Enter**.
11. If no errors occur, choose **Update** to save the record.
12. If error messages appear on the bottom of the screen, make correction(s), and choose **Enter**. When no error messages appear, choose **Update** to save the data.

Note: To reinstate the provider in Program 06 (Temporary Detention Order), choose Reinstate from the drop-down menu in the Selection field on the Provider Main Menu. Enter Program Code **06** with the begin date of the following date and the end date as applies. Enter the Provider Type of **100** – TDO Only accordingly.

5.6 Enter Provider Reinstate Data

To reinstate a Provider, follow the same procedures as an initial enrollment. The license must NOT have lapsed for length of time and the provider must have been in that program code previously. All appropriate documents must be verified and the Indefinite Agreement Indicator must be **I** to reactivate a provider.

Procedure

From the VaMMIS Main System Menu:

1. Choose the **Provider** icon.
2. You see the **Provider Main Menu** screen (PS-S-000).
3. Choose **Reinstate** from the drop menu in the **Selection** field.
4. Choose the **Update** radio button in the **Function** field.
5. Enter the Provider Identification Number in the **ID Value** field.
6. If no entry is made in the **ID Value** field, the Provider ID Number must be entered in the **Provider ID** field. Choose **Enter** to display the record.
7. Choose **Enter**.
8. You see the **Provider Location Information Reinstate** screen (PS-S-00103).
9. Enter data, and then choose **Enter**.
10. If no errors occur, choose **Update** to post the record.
11. If error messages appear on the bottom of the screen, make correction(s), choose **Enter**.
12. When no error messages appear, choose **Update** post the data.

If all edits are passed, choose Next and repeat the process for the next three screens. All required data elements must be entered and pass all edits for the enrollment add or update. Choose Update on screen 5 (PS-S-001-5). The provider information will be posted to the provider database. Proceed to the applicable screens to complete the Provider Enrollment and/or update.

For more details on specific screen navigation and field entries, or specific data elements, refer to the On-line Provider Subsystem User Manual, and/or the On-line HELP system.

5.7 Enter Provider Group Data

A Group is enrolled using the same provider Information screens used for an individual provider, with some exceptions. Use the same procedures for Enrolling a Medicaid Provider but change these elements:

- Group Type must be 01 for Group Practice and 02 for HMO.
- Enter Type 3 for Affiliation Groups on the Affiliation screen.

Once the Group Provider is added to the Provider database, the individual provider(s) may be added to the group record. The Provider Group record will also be updated for the associated group members.

Procedure

From the VaMMIS Main System Menu:

1. Choose the **Provider** icon.
2. You see the **Provider Main Menu** screen (PS-S-000).
3. Select **Group/Provider** from the drop-menu in the **Selection** field.
4. Choose the **Add** or **Update** radio button in the **Function** field.
5. Enter the Provider Identification Number in the **ID Value** field.
6. If no entry is made in the **ID Field**, enter the Provider ID number on the **Group/Provider** screen and choose **Enter** to display the record(s).
7. Choose **Enter** to display the **Provider/Group** screen.
8. Search through the data for a current open record. If no record or current open record is found, enter the individual Provider ID that is be enrolled within the Group ID.
9. After entering data for an Update, choose **Enter**.
10. If no errors occur, choose **Update** to save the record.
11. If error messages appear on the bottom of the screen, make correction(s) and choose **Enter**. When no error messages appear, choose **Update** save the data.

For more details on specific screen navigation and field entries, or specific data elements, refer to the On-line Provider Subsystem User Manual, and/or the online HELP system.

5.8 Enter Provider Affiliation Data

A provider enrolled in a Managed Care program(s) may choose to create an affiliation with one or more providers enrolled for a specfic or indefinite period of time. If the provider has more than one location, the affiliation must be created for the multiple location even though they are from the same provider. Other providers do not need to be enrolled in the Managed Care program(s) to create the affilliation. The Affililation Type must be **01**.

Procedure

From the VaMMIS Main System Menu:

1. Choose the **Provider** icon.
2. You see the **Provider Main Menu** screen (PS-S-000).
3. Select **Managed Care Affiliation** from the drop-menu in the **Selection** field.

4. Choose the **Add** or **Update** radio button in the **Function** field.
5. Enter the Provider Identification Number in the **ID Value** field.
6. Choose **Enter**.
7. You see the **Managed Care Affiliation** screen.
8. Enter data, and then choose **Enter**.
9. If no errors occur, choose Update to post the record.
10. If error messages appear on the bottom of the screen, make correction(s), choose **Enter**.
11. When no error messages appear, choose **Update** post the data.

For more details on specific screen navigation and field entries, or specific data elements, refer to the On-line Provider Subsystem User Manual, and/or the On-line HELP system.

5.9 Enter Provider Medicare Cross Reference Data

Provider(s) that participate with the Medicare Part A or Part B program must indicate on the Provider application the Medicare Provider Number, the Medicare Carrier/Intermediary name, the state in which the provider is enrolled and the Medicare Effective Date. The Medicare ID must be on the Provider database to allow Medicare Cross-Over claims to be processed. This allows the crossover claims to be paid without submitting a Title XVIII paper claim.

Procedure

From the VaMMIS Main System Menu:

1. Choose the **Provider** icon.
2. You see the **Provider Main Menu** screen (PS-S-000).
3. Select **Medicare Cross-Reference** from the drop-menu in the **Selection** field.
4. Choose the **Add** or **Update** radio button in the **Function** field.
5. Enter the Provider Identification Number in the **ID Value** field.
6. Choose **Enter**.
7. You see the **Medicare Cross-Reference** screen (PS-S-015).
8. Enter data, and then choose **Enter**.
9. If no errors occur, choose **Update** to post the record.
10. If error messages appear on the bottom of the screen, make correction(s), choose **Enter**.
11. When no error messages appear, choose **Update** post the data.

For more details on specific screen navigation and field entries, or specific data elements, refer to the On-line Provider Subsystem User Manual, and/or the On-line HELP system.

5.10 Enter Provider Rate Data

A First Health PEU supervisor is responsible for entering initial rates for Cost Settlement providers only – (Provider Types; 01, 02, 04, 06, 08, 10, 11, 12, 14, 15, 16, 17, 18, 19, 28, 29, 52, 53, 77, 85.) The rate is determined by Clifton Gunderson, contractor for DMAS. The Clifton Gunderson rate form is completed, with signatures of both an authorized signature of the Clifton Gunderson firm and DMAS. Do not place the provider in a Program Code until this form is received.

Procedure

From the VaMMIS Main System Menu:

1. Choose the **Provider** icon.
2. You see the **Provider Main Menu** screen (PS-S-000).
3. Select **Provider Rates** from the drop-menu in the **Selection** field.
4. Choose the **Add** or **Update** radio button in the **Function** field.
5. Leave the **ID Value** field blank.
6. Choose **Enter**.
7. You see the **Provider Individual Rate** screen.
8. Enter data, and then choose **Enter**.
9. If no errors occur, choose **Update** to post the record.
10. If error messages appear on the bottom of the screen, make correction(s), choose **Enter**.
11. When no error messages appear, choose **Update** post the data.

For more details on specific screen navigation and field entries, or specific data elements, refer to the On-line Provider Subsystem User Manual, and/or the On-line HELP system.

5.11 Enter Provider CLIA Data

The CLIA (Clinical Laboratory Improvement Amendments Laboratory) number is required for Laboratories – (Provider Type 70). Other provider types may provide laboratory services. To be in compliance with the Center for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all laboratory testing sites must have a CLIA certificate of waiver or certificate of registration to legally perform laboratory services rendered

on or after September 1, 1992. The certificate dates must cover the dates for enrolling in one or more Medicaid programs.

Procedure

From the VaMMIS Main System Menu:

1. Choose the **Provider** icon.
2. You see the **Provider Main Menu** screen (PS-S-000).
3. Select **Provider CLIA** from the drop-menu in the **Selection** field.
4. Choose the **Add** or **Update** radio button in the **Function** field.
5. Enter the **Provider Identification Number** in the **ID Value** field.
6. Choose **Enter**.
7. You see the **Provider CLIA Update** screen (PS-S-030).
8. Enter data, and then choose **Enter**.
9. If no errors occur, choose **Update** to post the record.
10. If error messages appear on the bottom of the screen, make correction(s), choose **Enter**.
11. When no error messages appear, choose **Update** post the data.

For more details on specific screen navigation and field entries, or specific data elements, refer to the On-line Provider Subsystem User Manual, and/or the On-line HELP system.

6.0 Maintain Provider Enrollment Documentation

Paper copies of Provider Enrollment agreements and other documentation must be maintained in PEU custody for three months from the date of processing. After three months, the batches of paper copies are sent to a contractor for shredding and disposal. A complete list of Provider Enrollment Agreements and samples is included in Section 8.5.3.

6.1 Prepare Provider Documentation for Storage

Provider enrollment documentation is batched and kept for three months from date of processing.

Procedure

1. Sort batches by Julian date.
2. The batch is reviewed by Quality Control Review for each process: change request, termination, EFT, DHP verification, letters, etc.
3. If the batch is incomplete, return the batch to the Provider Enrollment Representative for corrections.
4. When the batch is returned from the Provider Enrollment Representative, review it again for each process as outlined above.
5. If the batch is complete, put the batch in storage.

6.2 Prepare Batches of Provider Documentation for Disposal

After batches of Provider Enrollment documentation are kep on site for three months, the batches are disposed of.

Procedure

1. Check the batch's Julian date to ensure it is 3 months past the date of processing.
2. Remove any clips, rubber bands, or staples.
3. Place in the bin for disposal and recycling.

6.3 List of Provider Agreements

The provider agreements that accompany the Provider applicaition are included in the following list. A sample copy of each agreement is in Appendix F.

- Adult Care Residence Assisted Living Services Participation Agreement
- Home and Community Based Care Services Participation Agreement Adult Day Health Care
- Transportation Provider Participation Agreement
- Ambulatory Surgical Center Participation Agreement
- Clinic Participation Agreement
- Consumer-Directed Service Coordinator
- Durable Medical Equipment And Supplies Participation Agreement
- Early Periodic Screening, Diagnosis, And Treatment Program Participation Agreement
- Expanded Prenatal Care and Infant Care Coordination Participation Agreement
- Home And Community Based Care Services Participation Agreement AIDS Case Management
- Home And Community-Based Care Application For Provider Status As A Adult Day Health Care Provider
- Home And Community-Based Care Application For Provider Status As A Elderly Case Management Provider
- Home And Community-Based Care Application For Provider Status As A Family/Caregiver Training Provider
- Home And Community-Based Care Application For Provider Status As A Personal Care Provider
- Home And Community Based Care Services Participation Agreement Private Duty Nursing
- Home And Community Based Care Services Participation Agreement Respite Care
- Home And Community-Based Care Application For Provider Status As A Support Coordination Provider
- Home Health Participation Agreement
- Hospice Care Participation Agreement
- Hospital Participation Agreement
- Independent Laboratory Participation Agreement
- Mental Health & Mental Retardation & Substance Abuse Services & Developmental Disability Participation Agreement
- MR Waiver Application For Therapeutic Consultation
- Nurse Midwife Participation Agreement
- Nurse Practitioner Participation Agreement
- Nursing Home Participation Agreement
- Outpatient Rehabilitation Services Participation Agreement

- Personal Care
- Pharmacy Participation Agreement
- Physician Adult Care Residence Assessment Services Participation Agreement
- Physician-Directed Participation Agreement
- Private Duty Nursing
- Prosthetic/Orthotic Participation Agreement
- Residential Psychiatric Treatment For Children And Adolescents
- Respite Care
- School Division Participation Agreement
- School-Based Clinic Participation Agreement
- Specialized Care Participation Agreement
- Substance Abuse Clinic Participation Agreement
- Treatment Foster Care Case Management Agreement

7.0 Service the Provider Helpline

The Virginia PEU Helpline is a toll-free helpline offering Provider Enrollment information to Providers on all programs. Calls are answered by representatives who serve in both customer relations and data entry capacities. The Helpline is available from 8 am to 5 pm Monday through Friday, except on holidays observed by the Commonwealth of Virginia.

Roles and Responsibilities

PEU Manager: The PEU Manager oversees all staff located at the VMAP operations center. The PEU Manager directly supervises staff and provides orientation and training to new Provider Representatives. Duties the PEU Manager include:

- Monitor phone equipment to ensure all calls are answered promptly, all operators are working efficiently, and service levels are being met.
- Answer operator questions and assist them with problems.
- Prepare weekly status reports for the director and DMAS.
- Perform annual colleague reviews for staff.

Provider Representative: Each representative is responsible for the following tasks:

- Providing accurate information about Provider Enrollment as it relates to all Medical Assistance programs.
- Sending printed educational materials or other information about the program to providers requesting information.
- Making outgoing calls to Providers to correct or complete information given in previous mail or telephone contact.

Note: Screen shots of the Revs Usage Report Screens are at the end of this section.

7.1 Login and Logout of the Computer System

See the normal system logon procedure for logging onto your PC via the [redacted] network.

Procedure

See the normal system logon procedure for logging onto your PC via the [redacted] network.

7.2 Login and Logout of the Phone System

You login and logout of the phone system to ensure that all of the time you spend on the phone is properly accounted for.

Procedure

To Log into the system:

1. Press the **LOGIN** button on the phone keypad.
2. Enter the split number.
3. Enter a four-digit phone login number on the phone keypad.
4. Press **Auto In** to receive calls

To Log out of the system:

1. Press the button on the phone to log out.

Note: You only log out when you are leaving at the end of the day. If leaving your desk for any other reason, press the **Aux** key.

7.3 Respond to Incoming Calls

A Provider calls the Helpline for one or more of these reasons:

- To request an application.
- To get information.

In general, answer each incoming call in a courteous, professional manner. First determine the reason for the call through a question/answer dialogue with the caller, then make sure the caller understands what your action will be to meet the request.

Procedures

1. When the phone rings, the red light next to the **CO** button flashes.
2. Answer each call on the first ring. Do not let the phone ring more than three times before answering.
3. Press the **CO** button to open the line.
4. Don't begin speaking until the mouthpiece is next to your mouth. Don't let the caller hear only a part of your greeting.
5. Speak clearly into the mouthpiece. Use this greeting:
6. "Good Morning (afternoon/evening), this is (use your name). How may I help you?"
7. Determine the reason for call and follow the instructions below for each type of call.

Requests for Application

When a provider requests an application, you must print and mail material:

1. Complete a Request for Agreements letter.
    - ❖ Open MS Word.
    - ❖ Choose the **Open Folder** command.
    - ❖ Choose **native application.**
    - ❖ Go to the N:Vaimage/data drive.
    - ❖ Open the **Groups** folder.
    - ❖ Open the **Procedures** folder.
    - ❖ Open the **Request Letters** folder.
    - ❖ Choose the appropriate provider class type.
    - ❖ Choose the command **Save As.**
    - ❖ Save the file with these specifications:
        - – Use the Provider's last name.
        - – Use **RT** as the document type.
        - – Use **requestltr** as the document name.
        - – Enter your login ID.
    - ❖ Enter the appropriate fields on the request letter.
2. Notify the MEDALLION Unit, if the provider is requesting MEDALLION status.
3. Print 2 agreement forms.
    - ❖ Open MS Word.
    - ❖ Choose the **Open Folder** command.
    - ❖ Choose **nativeapplication**.
    - ❖ Go to the N:Vaimage/data drive.
    - ❖ Double-click on the **Groups** folder.
    - ❖ Double-click on the **Procedures** folder.
    - ❖ Double-click on **Agreements**.
    - ❖ Double-click on the appropriate provider class type.
    - ❖ Choose the **Print** icon on the toolbar.
4. Pick up all the forms from the printer and paperclip them together.
5. Place this package in the appropriate **In** box for mailing to the Provider.

Requests for Information (Verbal)

Requests for information may be answered on the phone by the Provider Representative, or may involve mailing written materials to the caller.

- Answer questions accurately and promptly.
- If a caller asks questions that cannot be answered immediately:
  - Take the caller's name and phone number and write down the question.
  - Repeat the information and question to ensure that you have the right information.
  - Inform the caller of when he/she can expect an answer. Be as precise as possible.
  - Examples:

    "I should have an answer to your question in a few minutes. I'll call you right back."

    "It may take awhile to find the answer you need. I will call you back tomorrow afternoon."

  - Always return the call when you promised to. If the information is still not available at the time you promised to call back, call the customer and tell them the progress made, then specify another time for returning the call.

The caller asks to speak to a Supervisor or Manager

1. Politely ask the caller for general information about the situation to be discussed.
2. Find the appropriate manager and describe the situation.
3. Follow the manager's instructions about transferring the call.

Enrollments

There are a variety of enrollment transactions that operators must process for providers. Here is a list of some:

- Adding new Medicaid providers and correcting enrolled provider data.
- Adding new MEDALLION providers and correcting enrolled provider data.
- Changes to Provider information (All change requests must be in writing)
  - Change of address.
  - Service Center.
  - Rates.
- Re-certifications.
- Cancellations or terminations.

Detailed instructions for each of these transactions are included in Section 8.3 of this manual.

Referrals

Representatives may refer callers to other agencies when appropriate. Check the contact list for agency phone numbers. Some typical referrals include:

- Department of Health Professions (DHP) – Refer providers who have questions about their license with DHP.
- Department of Medical Assistance Services (DMAS) – Refer providers who have these questions:
  - ❒ Questions about a specific claim.
  - ❒ General billing questions.
  - ❒ Payments.
  - ❒ Subcontracting with HMOs
- Clifton Gunderson – Refer providers who must be cost-settled to establish their rates.

7.4 Make Outgoing Calls

Provider Representatives routinely calls Providers to do these tasks:

- Follow up on previous phone calls.
- Respond to messages left on voice mail (Call backs).
- Clarify the TIN (Tax Identification Number) provided to First Health or the IRS.
- Request current address information in writing.

Regardless of the reason for the call, follow the guidelines below when making outgoing calls.

Procedure

1. Be prepared, always have the information in front of you and know what needs to be discussed with the provider or party called.
2. When the call is answered, always identify yourself and the reason for calling.
   - ❖ Example:

     "Hello, my name is (your name) and I am with the Provider Enrollment Unit, Virginia Medicaid. I am calling in reference to…."
3. Always speak clearly into the mouthpiece or headset.
4. Be polite and courteous when requesting information.
5. Conclude with a warm gesture.

Call Backs

1. Check the callback schedule at the beginning of the day. Provider Representatives should check the callback schedule daily to see who has been assigned callbacks for the day.
2. Retrieve messages from voice mail.
3. Place outgoing calls.
4. Complete a Notepad entry.

Retrieve Messages from Voice Mail

1. Access the **Helpline Voice Mail** system:
    - ❖ Dial **436** from any phone. Follow the instructions given to you by the system.
    - ❖ Press **#**.
    - ❖ Dial **9998** at the **Mailbox Number** prompt.
    - ❖ Dial **9998** for the password.
2. Listen to the message and take appropriate notes.
3. Delete the message from voice mail by pressing **3**. Confirm the delete by pressing **#**.
4. Repeat Steps 2 and 3 above until all messages have been retrieved.
5. Review the messages, applying the following criteria.
    - ❖ If a call was a hang-up or not enough information was provided, do nothing.
    - ❖ If there was enough information provided to determine a telephone number or one given, call the provider and offer assistance. If there is still no answer, try to call later in the day.
    - ❖ If an answering machine answers, leave a message that you are responding to their message and to please call the HELP desk at 1-888-829-5373.
    - ❖ If someone other than the caller answers, leave a message that you are responding to (caller's name) message, and if they still need assistance, they should call the Helpline at 1-888-829-5373.

7.5 Use Professional Telephone Techniques

Proper use of the telephone will keep your customers satisfied and confident that they are getting quality service. Always use positive language with each customer. Customers want to feel that their problems are the only ones gaining your attention. The guiding principles of professional, effective telephone service are listed below:

- The phone should be answered on the first ring, if possible, and after no more than two rings.
- Greet the caller with an appropriate business greeting and introduce yourself.
- Request the caller's first and last name.
- Transfer the call only if necessary, and make sure you are transferring the call to the right person.
- Tell your customer to whom you are transferring the call.
- Summarize the customer's message to the person to whom you are transferring the call.
- Always take a complete message from the caller.
- If you have to place a caller on hold, tell the caller why and how long they will be on hold.
- If you need to interrupt a caller, try to do so without being rude. For example, state their name, pause, and say, "I need to interrupt you for just a second."
- Always protect confidential information on patient's records.
- Actively listen to the customer's concerns. Use the caller's name during conversation.
- Promise less than you deliver.
- When closing the conversion, thank the person for calling, and speak in the past tense.

8.0 Provide Assistance to DMAS

First Health may be contacted to research inquires made to DMAS from providers. The research typically involves gathering several items of documentation concerning a provider's enrollment or re-certification. The information is sent to DMAS or if requested First Health works with a provider to resolve issues. PEU also does provider outreach when it is identified that a proactive contact with a provider will assist DMAS.

8.1 Assist DMAS with Liaison and Coordination

The PEU Manager or Supervisors are contacted by DMAS regarding research required to resolve Provider Enrollment issues.

Procedure

1. Receive research request from DMAS
2. Using all imaged source documents and on-line files, research the request and respond to DMAS with the findings.
3. Image all documents obtained from other sources during the period of research.

8.2 Assist DMAS with Resolution of Concerns and Appeals

First Health supports DMAS in resolving Provider concerns and appeals. All imaged documentation is utilized and procedures are reviewed to respond to the issues. If other agencies are involved in the decision making process, these agencies are contacted during the review.

Procedure

1. Receive request for support from DMAS
2. Review available source documents
3. Interview affiliated resources for additional input.
4. Respond to DMAS with findings
5. Image all research documents and the request for support

Appendix A HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) provides, among other things, strong protection for personal health information. It gives individuals certain rights concerning their health information, sets boundaries on how it is used, establishes formal safeguards, and holds violators accountable. The HIPAA Privacy regulations give the individual the right to control his own identifiable health information even when it is created and maintained by others. The regulations went into effect on April 14, 2003.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

PHI may not be released to anyone who is not authorized to receive the information or who does not have a need to know that information. Information released will be the minimum necessary to achieve the stated goal unless the member releases the information, the information is required by law, or is necessary for treatment. Authorization is always required for any use or disclosure of PHI that is not permitted under the Privacy regulations.

To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose PHI, with certain limits and protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

Please refer to the Final Privacy Rule published in the Federal Register on December 28, 2000, for regulatory details about permitted uses and disclosures of PHI.

Appendix B Weekly DHP Update Instructions

Step 1: DHP Download

1. Open the Windows Explorer program.
2. Go to N:\groups\vpeu\DHP Licensure and click on **File**.
   - ❖ Click on **New**
   - ❖ Click on **Folder**
   - ❖ Name the folder. Enter the name as **dhp** followed by the current date (Example: dhp021203) and press **Enter**.
3. Open the Internet Explorer program.
4. Go to the Virginia Department of Health Professions website:
   - ❖ http://www.dhp.state.va.us/
5. Click on the **Download License Lists** link.
6. Click on the **Virginia Information Providers Network (VIPNet)** link.
7. Click on the **Access As A Subscriber** link.
8. Enter your user name and password at the **Network Password** prompt.
   - ❖ VIPNet issued an individual user name and password to the following individuals:
     - – [redacted], VMAP Provider Enrollment Unit
     - – [redacted], VMAP QC Unit
     - – [redacted], Network Coordinator, VMAP Provider Enrollment Unit
     - – [redacted], QC Coordinator, VMAP Provider Enrollment Unit
9. Click on the board that you would like to download. The following boards are required:

   - Counseling
   - Dentistry
   - Medicine
   - Nursing
   - Optometry
   - Pharmacy
   - Psychology
   - Social Work
   - Speech Pathology/Audiology

10. After highlighting the board you would like to download, click on the **Proceed** button.
11. Click on the **Start Downloading** button.

12. At the **File Download** prompt, choose the **Save The File To Disk** option and click on the **OK** button.
13. At the **Save As** prompt, locate the folder you created on the N: drive ([redacted]).
14. Click on the **Save** button.
15. Repeat Steps 10 – 14 until all the required boards have been downloaded to the folder.

Step 2: Update DHP Access Database

1. Open the **Access** program.
2. Open the **DHP Licensure** database. Database location:
   - ❖ [redacted]
3. Minimize the **DHP Current License Search**.
4. Maximize the **DHP License**.
5. Click on the **Tables** tab.
6. Click on **tblTypes**.
7. Click on **Open.**
8. Change the Path name to match the file in which you downloaded the board information. They must match exactly. You must have a slash at the end of the folder name.
9. Change the Data name to the current month.
10. Close the **Tables** screen.
11. Click on the **Forms** tab.
12. Click on **frmImport.**
13. Click on **Open.**
14. Maximize the **Import** window.
15. Click on **Import.** This will create a backup, delete the current file, import all text files in the directory, delete all providers with an end date that is over one year old and create an export text file. The status of each step will be displayed in the window.
16. When the **Exporting Data** step is completed, close the Access program.

Note: When the DHP Access database is updated using the aforementioned procedures, an export text file is created on the N: drive ([redacted]). The file is date specific. Example: If the DHP Access database were updated on 02/12/03, the

export text file that was created would be named [redacted]. Said export text file is currently uploaded to the mainframe dataset '[redacted]' on a weekly basis using the **Transfer File** function in the [redacted] mainframe system.

Appendix C U.S. Postal Standards

Please view the following website for complete details:

http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf

First Health Services Corporation®
A Coventry Health Care Company

Appendix D
Provider Enrollment Unit Post NPI Implementation Procedures Manual

Version 1.1

June 11, 2008

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HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.1	04/07/08	Documentation Management	Formatted to new template and edited all sections.

Table of Contents

HIPAA Privacy Rules **2**
Revision History **3**
Table of Contents **4**
1.0 API Maintenance Screen **6**
1.1 General Information 6
1.2 Screen Access 6
1.3 Entering Provider Data 9
1.4 Error Messages 12
2.0 NPI Maintenance Screen **12**
2.1 Screen Access 13
2.3 Entering Provider Data 16
2.4 Error Messages 18
3.0 Base ID Maintenance **21**
3.1 General Information 21
3.2 Screen Access 21
3.3 Entering Provider Data 23
3.4 Error Messages 27
4.0 Billing Address Maintenance Screen **29**
4.1 General Information 29
4.2 Screen Access 29
4.3 Entering Provider Data 31
4.4 Error Messages 33
5.0 Servicing Address Maintenance Screen **37**
5.1 General Information 37
5.2 Screen Access 37
5.3 Entering Provider Data 39
5.4 Error Messages 41
6.0 Group / Provider Maintenance Screen **44**
6.1 General Information 44
6.2 Screen Access 44
6.3 Entering Provider Data 46
6.4 Error Messages 49
7.0 Provider / Group Maintenance Screen **53**
7.1 General Information 53
7.2 Screen Access 53
7.3 Entering Provider Data 55
7.4 Error Messages 57
8.0 Entering Primary Billing Information **62**
8.1 General Information 62

8.2 Screen Access 62
8.3 Entering Provider Data 64
8.4 Entering Provider Data 69
9.0 Entering an NPI for an Existing Provider 73
9.1 General Information 73
9.2 Screen Access 73
10.0 Canceling Provider Eligibility Screen 78
10.1 General Information 78
10.2 Screen Access 78
10.3 Entering Provider Data 81
10.4 Error Messages 84
11.0 Application Tracking Procedures Screen 88
11.1 General Information 88
11.2 Screen Access 88
12.0 General Information (Provider Application Tracking Inquiry) 91
12.1 Screen Access (Provider Application Tracking Inquiry) 91
12.2 Enter Provider Data (Provider Application Tracking Inquiry) 93
12.3 Error Messages (Provider Application Tracking Inquiry) 96
13.0 General Information (Provider Application Add/Update) 99
13.1 Screen Access (Provider Application Add/Update) 99
13.2 Entering Provider Data (Provider Application Add/Update) 101
13.3 Error Messages (Provider Application Add/Update) 107
14.0 General Information (Provider Application Approval) 113
14.1 Screen Access (Provider Application Approval) 113
14.2 Enter Provider Data (Provider Application Approval) 115
14.3 Error Messages (Provider Application Approval) 118
15.0 General Information (Provider Letter Information Inquiry/Update) 121
15.1 Screen Access (Provider Letter Information Inquiry/Update 121
15.2 Enter Provider Data (Provider Letter Information Inquiry/Update) 123
15.3 Error Messages (Provider Application Approval) 126

1.0 API Maintenance Screen

1.1 General Information

The API Maintenance Screen updates an API Provider ID to an NPI Provider ID. When the API is keyed, all related information is displayed on the first detail line at the bottom of the screen. When the NPI is keyed, all related information is displayed on the second detail line at the bottom of the screen. When all edits have been passed, the Update button will make the change permanent.

1.2 Screen Access

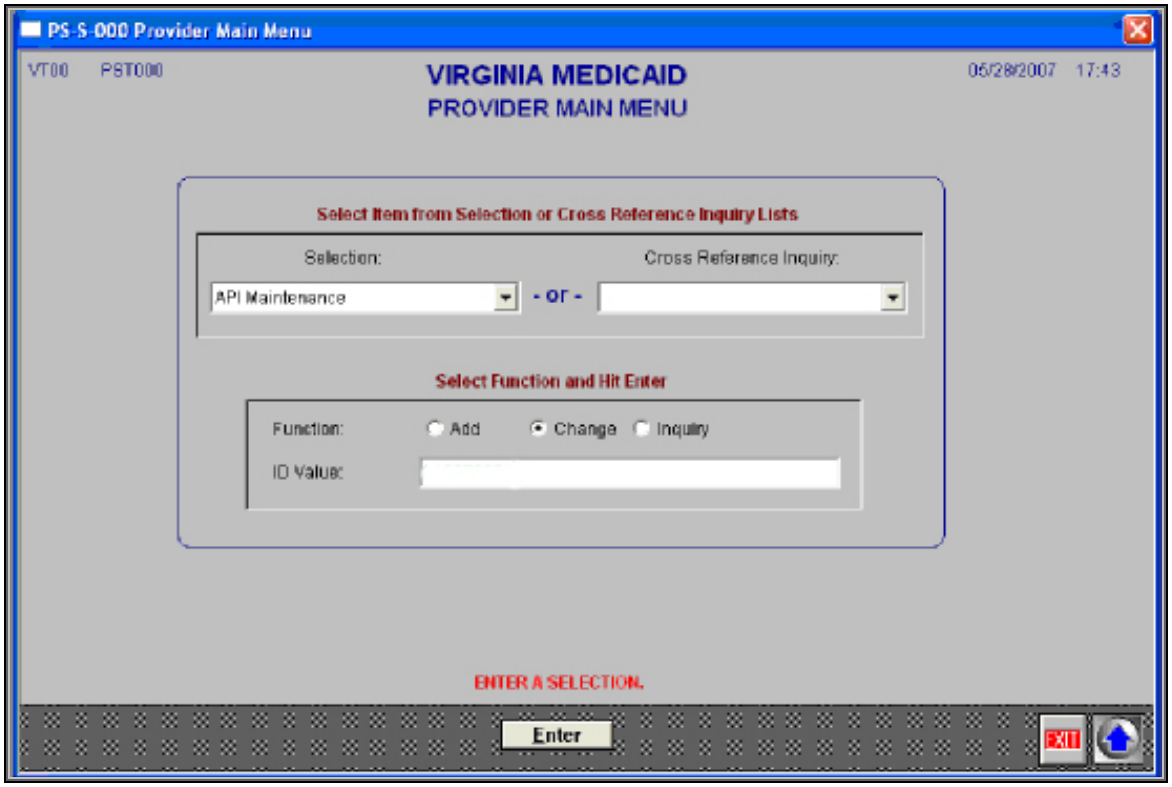
From the VaMMIS Main System Menu choose the Provider Sub-system:

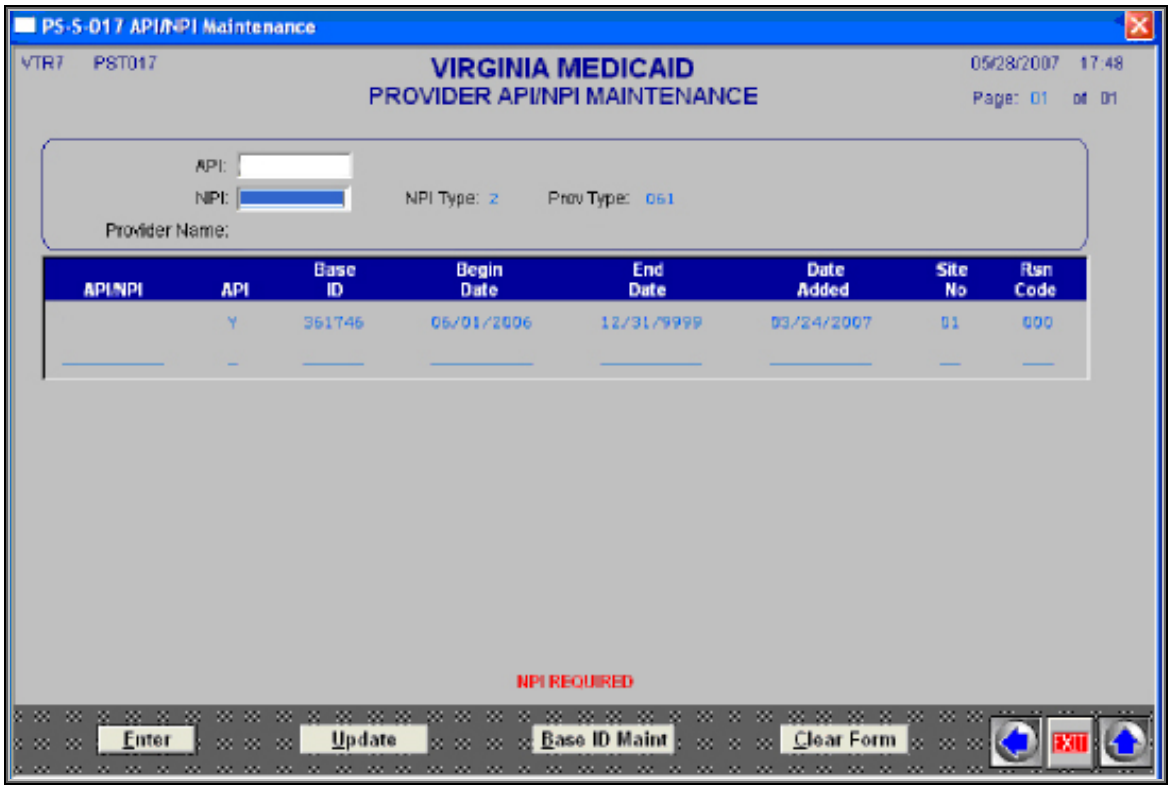
1. On the Provider Main Menu screen, choose API Maintenance from the Selection drop-down menu.
2. Select the Change radio button in the Function field.
3. Enter the Provider Identification Number in the ID Value field.

   Note: This can only be an API.

4. Select Enter.

RF-S-010 Main System Menu
VS00 RFT010
VIRGINIA MEDICAID
MAIN SYSTEM MENU
05/28/2007 17:33
Recipient
Financial
Management & Admin Reporting
Assessments
Provider
Prior Authorization
EPSDT
Drugs
Reference
Automated Mailing
MICC
Batch On-Request Reports
Invoice Processing
Surveillance & Utilization Review
TPL Maintenance
Click Picture to Enter Subsystem
CANCEL
EXIT


PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
05/28/2007 17:43
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cross Reference Inquiry:
API Maintenance
- or -
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION.
Enter
EXIT

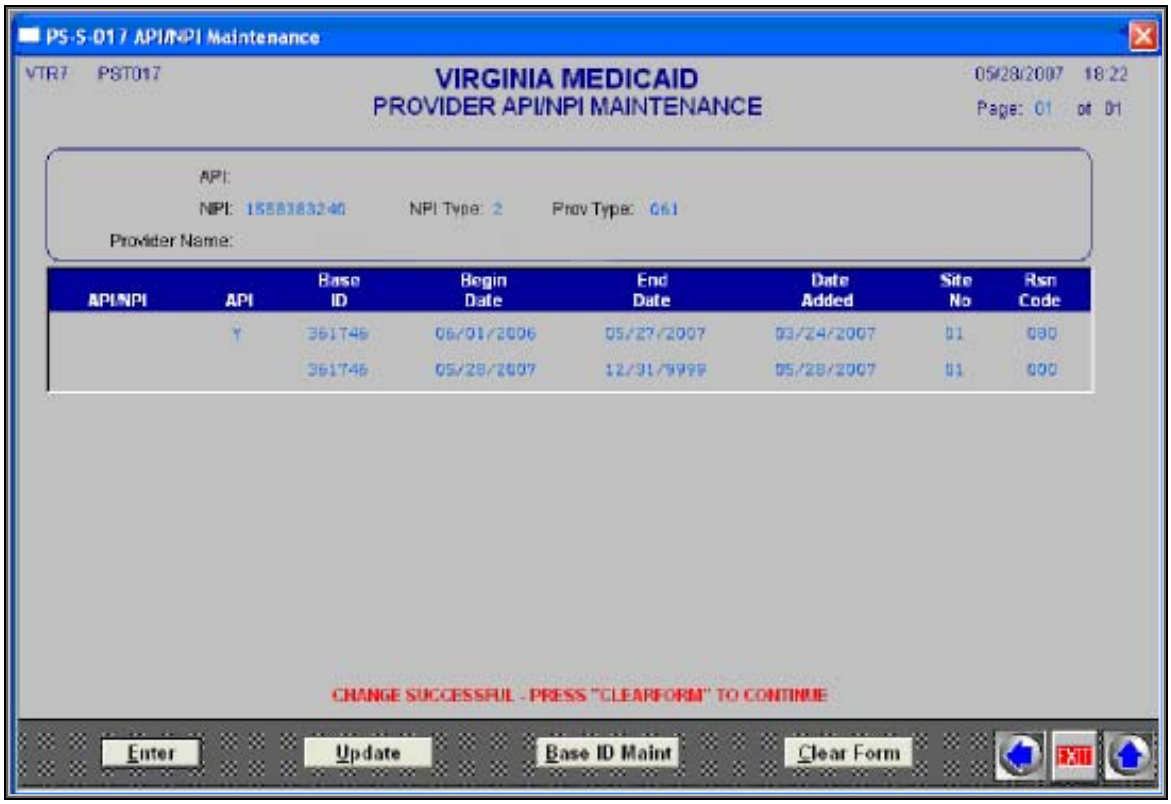

PS-S-017 API/NPI Maintenance
VTR7 PST017
VIRGINIA MEDICAID
PROVIDER API/NPI MAINTENANCE
05/28/2007 17:48
Page: 01 of 01
API:
NPI:
NPI Type: 2
Prov Type: 061
Provider Name:
API/NPI
API
Base ID
Begin Date
End Date
Date Added
Site No
Rsn Code
Y
361746
06/01/2006
12/31/9999
03/24/2007
01
000
NPI REQUIRED
Enter
Update
Base ID Maint
Clear Form
EXIT

1.3 Entering Provider Data

1. After all data has been entered, click Enter to view edits.
2. Correct any errors.
3. Click Update.

Screen	Data Element	Description	Value You Key	Comments
PS-S-017	API	Atypical Provider Identifier. A unique 10-digit identification number assigned by VaMMIS to a non-healthcare provider.	10-digit API	N/A
PS-S-017	NPI	National Provider Identifier. A unique 10-digit number assigned to a healthcare provider by CMS.	10-digit NPI	N/A
PS-S-017	Provider Name	The name of the provider	N/A	System displayed
PS-S-017	NPI Type	This field contains the value of *1* if the NPI/API provider is an individual and it is a *2* if the NPI provider is a corporation.	N/A	System displayed
PS-S-017	Prov. Type	A code that designates the classification of a provider under the State plan	N/A	System displayed
PS-S-017	API/NPI	Atypical Provider Identifier/National Provider Identifier	N/A	System displayed
PS-S-017	Provider API Indicator	This field contains a *Y* when the Provider Number is an Atypical Provider ID.	N/A	System displayed

Screen	Data Element	Description	Value You Key	Comments
PS-S-017	Base ID	A unique identification number used to associate multiple provider identification numbers to a single provider.	N/A	System displayed
PS-S-017	Begin Date	This field contains the date that the cross reference row was established on the table.	N/A	System displayed
PS-S-017	End Date	This field contains a date if the cross reference row is replaced with a more current row of data.	N/A	System displayed
PS-S-017	Date Added	This is the date that the NPI was added to the MMIS. If the NPI is entered after conversion has been performed, this is the date the NPI was entered online.	N/A	System displayed
PS-S-017	Site No	This field contains a consecutive number for each unique location an NPI provider is using for a servicing address. An NPI may have multiple provider types that share the same servicing address. They also may have multiple servicing addresses.	N/A	System displayed
PS-S-017	RSN Code	Reason code value describing the action or status of a Provider NPI XREF record	N/A	System displayed


PS-S-017 API/NPI Maintenance
VTR7 PST017
VIRGINIA MEDICAID
PROVIDER API/NPI MAINTENANCE
05/28/2007 18:22
Page: 01 of 01
API:
NPI: 1588383240 NPI Type: 2 Prov Type: 061
Provider Name:
API/NPI API Base ID Begin Date End Date Date Added Site No Rsn Code
Y 361746 06/01/2006 05/27/2007 03/24/2007 01 000
361746 05/28/2007 12/31/9999 05/28/2007 01 000
CHANGE SUCCESSFUL - PRESS "CLEARFORM" TO CONTINUE
Enter
Update
Base ID Maint
Clear Form
EXIT

1.4 Error Messages

Screen	Error	Description	Value You Key	Comments
PS-S-017	8921	API INVALID	Key in a valid API	N/A
PS-S-017	8931	API IS ALREADY CHANGED TO NPI, FUNCTION IS NOT VALID	N/A	Number keyed is an inactive API or is already updated
PS-S-017	8953	API NOT FOUND	Key in a valid API	N/A
PS-S-017	8923	API NOT VALID FOR THIS PROCESS	Key in an NPI instead of an API	N/A
PS-S-017	8952	API REQUIRED	Key in a valid API	N/A
PS-S-017	8954	BASE ID ALREADY LINKED TO NPI XXXXXXXXXX. UPDATE NOT PERMITTED.	N/A	Cannot have 2 NPIs with the same Base ID
PS-S-017	8930	BASE ID MISMATCH – USE BASE ID MAINTENANCE.	N/A	NPI move invalid, Base ID mismatch.
PS-S-017	8928	CHANGE SUCCESSFUL – PRESS "CLEARFORM" TO CONTINUE	Change completed, press refresh for next task	N/A
PS-S-017	2190	EDITS MUST BE VALIDATED BEFORE THIS FUNCTION CAN BE USED CHOOSE ENTER.	N/A	Information message
PS-S-017	8932	NPI INVALID - CHECK DIGIT ERROR	Key in a valid NPI	N/A
PS-S-017	4186	NPI IS INVALID	N/A	Information message
PS-S-017	8922	NPI REQUIRED	Key in a valid NPI	N/A
PS-S-017	8927	PRESS "UPDATE" TO CONFIRM CHANGES OR PRESS "CLEARFORM"	Press update to keep change or refresh screen	N/A

2.0 NPI Maintenance Screen

This screen updates an NPI Provider ID by moving all servicing locations to a new NPI number or by linking or unlinking servicing locations to/from the NPI. In ADD Mode, you can link a Legacy ID to an existing NPI. This Legacy ID cannot have an existing link to a different NPI. In CHG Mode, you can move the NPI to a new NPI value or unlink Legacy IDs.

2.1 Screen Access

From the VaMMIS Main System Menu choose the Provider Sub-system:

1. On the Provider Main Menu screen, choose NPI Maintenance from the Selection drop-down menu.
2. Select the Update radio button in the Function field for NPI Moves and Legacy Link deletes.
3. Select the Add radio button in the Function field for Legacy Link adds.
4. Enter the Provider Identification Number in the Old NPI field.

   Note: This must be an NPI only.

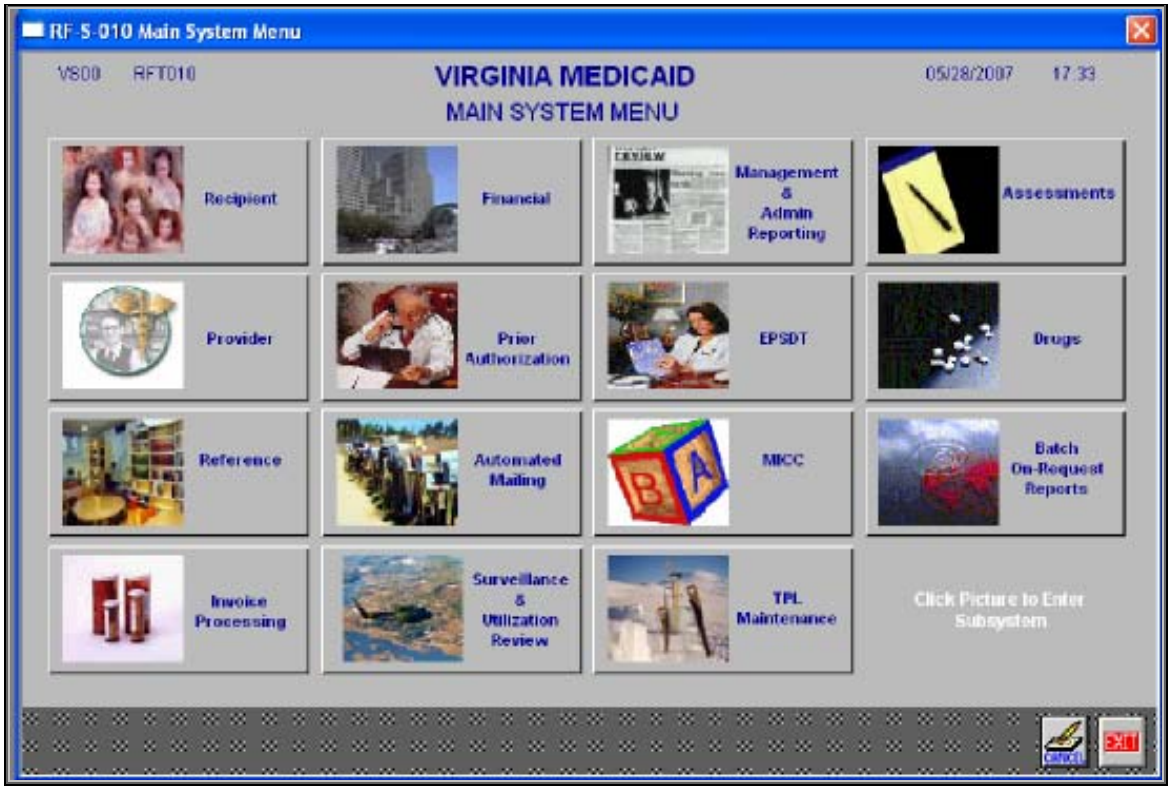
5. For an NPI Move, enter the Provider Identification Number in the New NPI field.

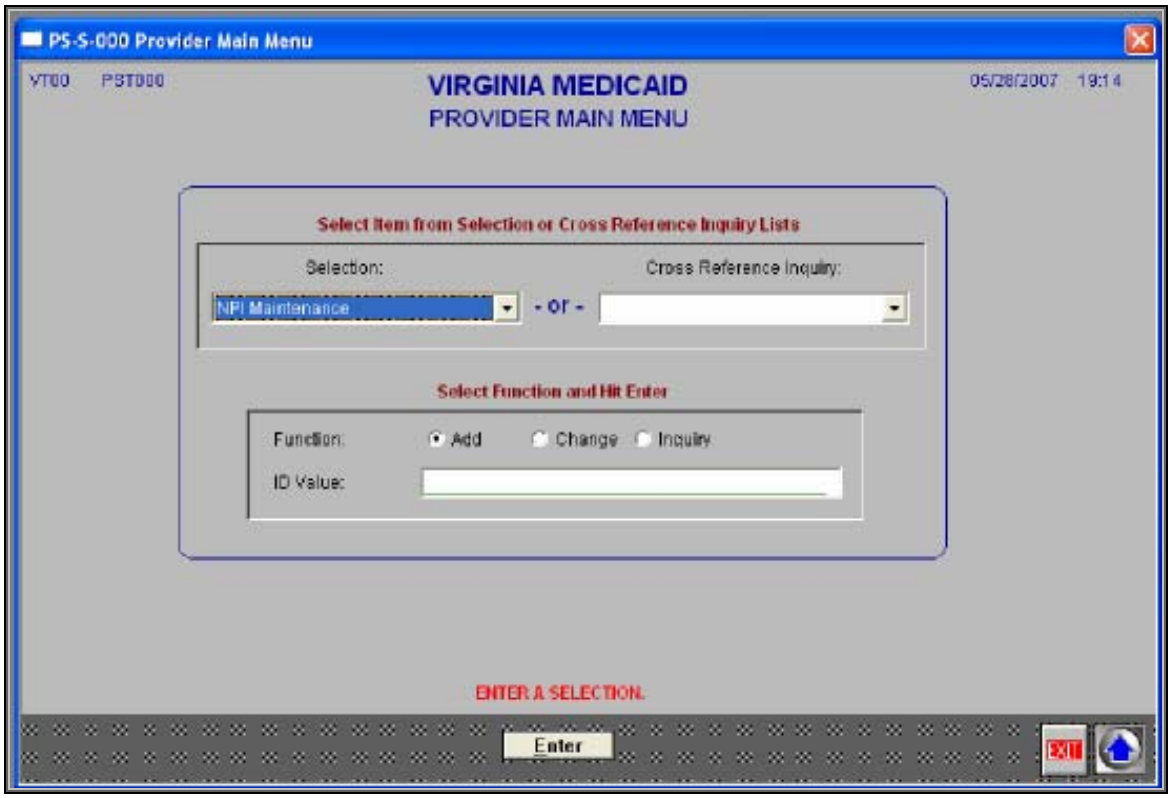
   Note: This must be an NPI only.

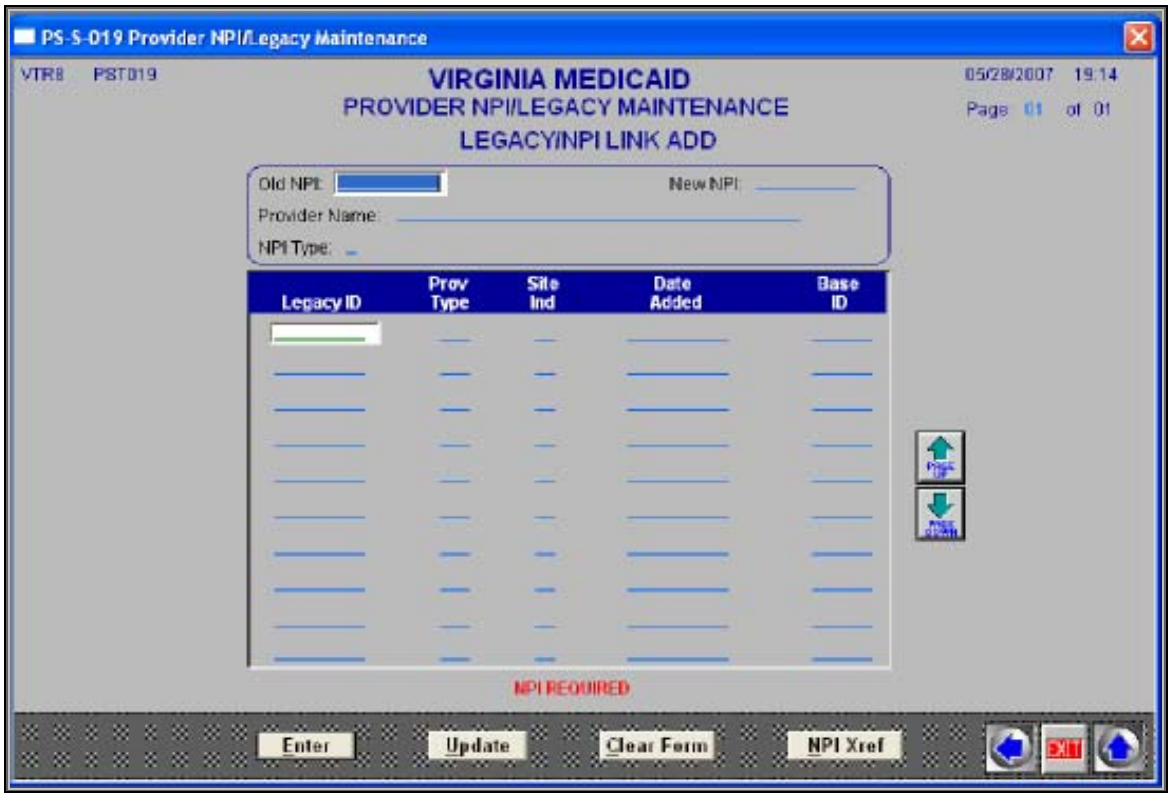
6. For Legacy Link/Un-link maintenance, leave the New NPI blank, and enter a Provider ID into the Legacy ID field.

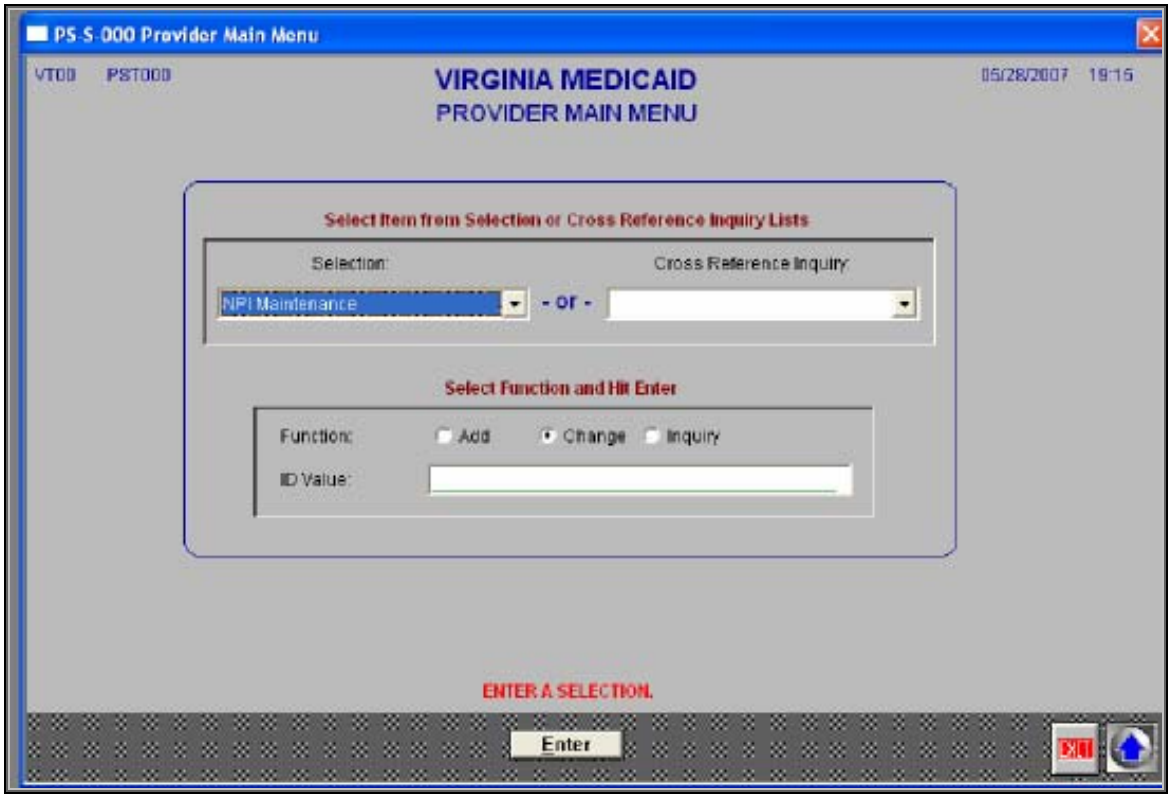
   Note: This is for a Legacy ID only.

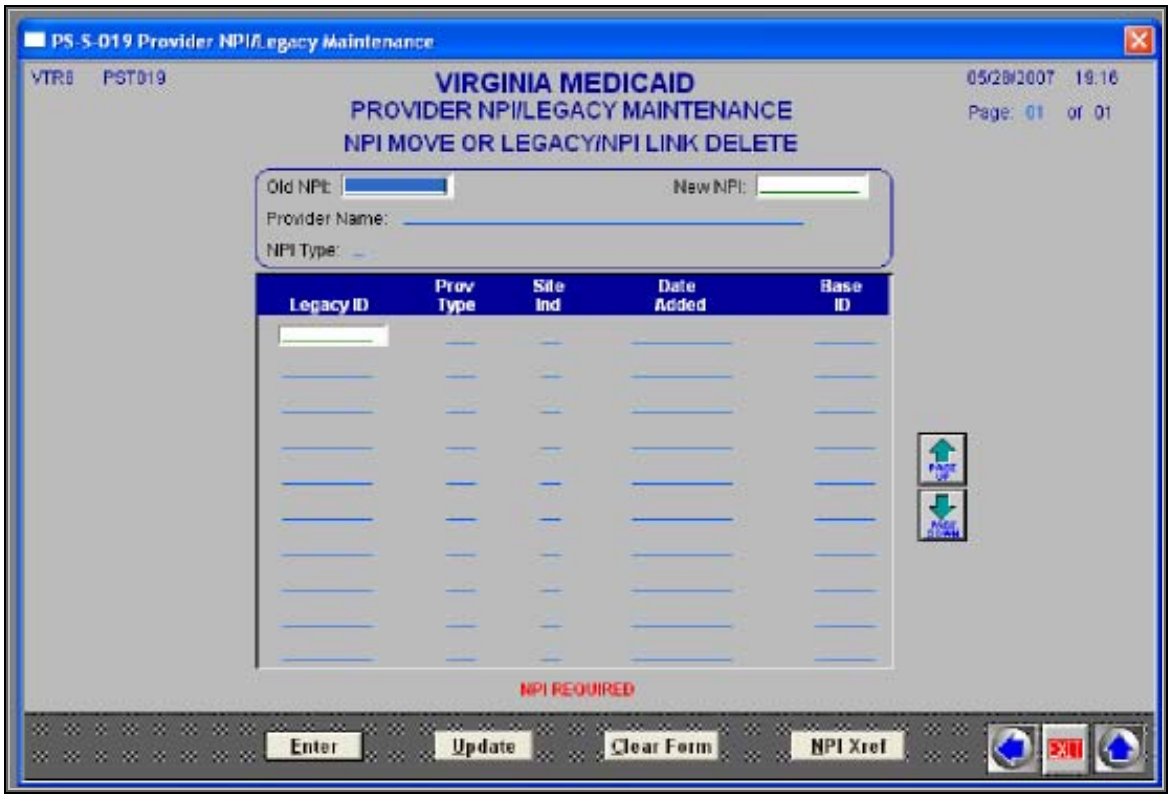
7. Then choose Enter.
8. When all edits are passed successfully, choose Update to retain changes.


RF-S-010 Main System Menu
VS00 RFT010
VIRGINIA MEDICAID
MAIN SYSTEM MENU
05/28/2007 17:33
Recipient
Financial
Management & Admin Reporting
Assessments
Provider
Prior Authorization
EPSDT
Drugs
Reference
Automated Mailing
MICC
Batch On-Request Reports
Invoice Processing
Surveillance & Utilization Review
TPL Maintenance
Click Picture to Enter Subsystem
CANCEL
EXIT


PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
05/28/2007 19:14
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cross Reference Inquiry:
NPI Maintenance
- or -
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION.
Enter
EXIT


PS-S-019 Provider NPI/Legacy Maintenance
VTR8 PST019
VIRGINIA MEDICAID
PROVIDER NPI/LEGACY MAINTENANCE
LEGACY/NPI LINK ADD
05/28/2007 19:14
Page 01 of 01
Old NPI:
New NPI:
Provider Name:
NPI Type:
Legacy ID
Prov Type
Site Ind
Date Added
Base ID
NPI REQUIRED
Enter
Update
Clear Form
NPI Xref
EXIT


PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
05/28/2007 19:15
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cross Reference Inquiry:
NPI Maintenance
- or -
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION.
Enter
EXIT



2.3 Entering Provider Data

1. After all data has been entered, click Enter to view edits.
2. Correct any errors.
3. Click Update.

Screen	Data Element	Description	Value You Key	Comments
PS-S-019	Old NPI/New NPI/Legacy ID National Provider Identifier	NPI – National Provider Identifier. A unique 10-digit number assigned to a healthcare provider by CMS. Legacy ID – A unique 9-digit identification number assigned to a provider by VaMMIS.	To change an existing NPI to a new NPI, enter the existing NPI in the Old NPI field and the new NPI in the New NPI field. To link a Legacy ID to an NPI, enter the NPI in the Old NPI field and enter the Legacy ID to be linked in the Legacy ID field. Click Enter to apply the link and to obtain a new line for another Legacy ID if you need to add more.	N/A

Screen	Data Element	Description	Value You Key	Comments
PS-S-019	Provider Name	The name of the provider	N/A	System displayed
PS-S-019	NPI Type	This field contains the value of *1* if the NPI/API provider is an individual and it is a *2* if the NPI provider is a corporation.	N/A	System displayed
PS-S-019	Prov Type	A code that designates the classification of a provider under the State plan	N/A	System displayed
PS-S-019	Site Ind.	This field contains a consecutive number for each unique provider type and location combination an NPI provider is using An NPI may have multiple provider types that share the same servicing address. They also may have multiple servicing addresses. For each combination of servicing address and provider type, there is a separate Site.	N/A	System displayed
PS-S-019	Date Added	This is the date that the NPI was added to the MMIS. If the NPI is entered after conversion has been performed, this is the date the NPI was entered online.	N/A	System displayed

Screen	Data Element	Description	Value You Key	Comments
PS-S-019	Base ID	A unique identification number used to associate multiple provider identification numbers to a single provider. Every provider has a Base ID assigned.	N/A	System displayed

2.4 Error Messages

Screen	Error	Description	Value You Key	Comments
PS-S-019	71	ALREADY AT THE FIRST PAGE; CANNOT SCROLL FURTHER	N/A	Information message
PS-S-019	72	ALREADY AT THE LAST PAGE; CANNOT SCROLL FURTHER	N/A	Information message
PS-S-019	8923	API NOT VALID FOR THIS PROCESS	Key in an NPI instead of an API	N/A
PS-S-019	8930	BASE ID MISMATCH – USE BASE ID MAINTENANCE.	N/A	NPI move invalid, Base ID mismatch.
PS-S-019	8939	BASE ID MISMATCH. LEGACY ID CANNOT BE LINKED.	N/A	Link failed because Legacy has different Base Id
PS-S-019	8936	CANNOT PERFORM NPI MOVE AND LEGACY/NPI UNLINK TOGETHER. DO SEPARATELY.	N/A	Must perform tasks separately
PS-S-019	8928	CHANGE SUCCESSFUL – PRESS "CLEARFORM" TO CONTINUE	Change completed, press refresh for next task	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-019	2190	EDITS MUST BE VALIDATED BEFORE THIS FUNCTION CAN BE USED CHOOSE ENTER.	N/A	Information message
PS-S-019	8935	EITHER NEW NPI OR LEGACY ID REQUIRED	New NPI or Legacy ID required on this screen	N/A
PS-S-019	15	FUNCTION CHOSEN IS INVALID	N/A	Choose another function.
PS-S-019	8949	LEGACY ID ALREADY LINKED TO API XXXXXXXXXX. UPDATE NOT PERMITTED.	N/A	Use API maintenance for this task.
PS-S-019	8938	LEGACY ID ALREADY LINKED TO NPI XXXXXXXXXX. UPDATE NOT PERMITTED.	N/A	Link failed because Legacy linked to other NPI
PS-S-019	8941	LEGACY ID INVALID	Key in a valid Legacy ID	N/A
PS-S-019	8942	LEGACY ID NOT FOUND	Key in a valid Legacy ID	N/A
PS-S-019	8937	LEGACY ID NOT LINKED TO NPI XXXXXXXXXX	N/A	Unlink failed because Legacy not linked to NPI
PS-S-019	8940	LEGACY ID REQUIRED	Key in a Legacy ID	N/A
PS-S-019	8948	LEGACY LINK TO NPI SUCCESSFUL, ENTER NEXT LEGACY.	Update completed. Key in next task	N/A
PS-S-019	8946	LEGACY UNLINK FROM NPI SUCCESSFUL. ENTER NEW NPI OR NEXT LEGACY.	Update completed. Key in next task	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-019	8929	NEW NPI CANNOT MATCH OLD NPI	N/A	Old NPI and New NPI cannot be the same nbr.
PS-S-019	8933	NEW NPI EXISTS - MUST UNLINK LEGACYS FROM OLD NPI AND LINK TO NEW NPI.	N/A	Must use link/unlink function instead of move
PS-S-019	64	NO DATA TO SCROLL	N/A	Information message No action needed.
PS-S-019	8932	NPI INVALID - CHECK DIGIT ERROR	Key in a valid NPI	N/A
PS-S-019	8874	NPI NOT FOUND	N/A	NPI not on database
PS-S-019	8922	NPI REQUIRED	Key in a valid NPI	N/A
PS-S-019	8943	NPI TYPE MISMATCH. LEGACY ID CANNOT BE LINKED.	N/A	Cannot mix NPI types on the same NPI
PS-S-019	8927	PRESS "UPDATE" TO CONFIRM CHANGES OR PRESS "CLEARFORM"	Press update to keep change or refresh screen	N/A
PS-S-019	4120	RECORDS DISPLAYED	N/A	Information message No action needed.
PS-S-019	8944	SYSTEM ERROR. NPI SELECT FROM PS_NPI_XREF RETURNED -811 SQLCODE.	N/A	System Error - 811. Notify IS Department
PS-S-019	8947	NPI MOVE SUCCESSFUL. PRESS "CLEARFORM" TO CONTINUE	Update completed. Choose Refresh for next task.	N/A

3.0 Base ID Maintenance

3.1 General Information

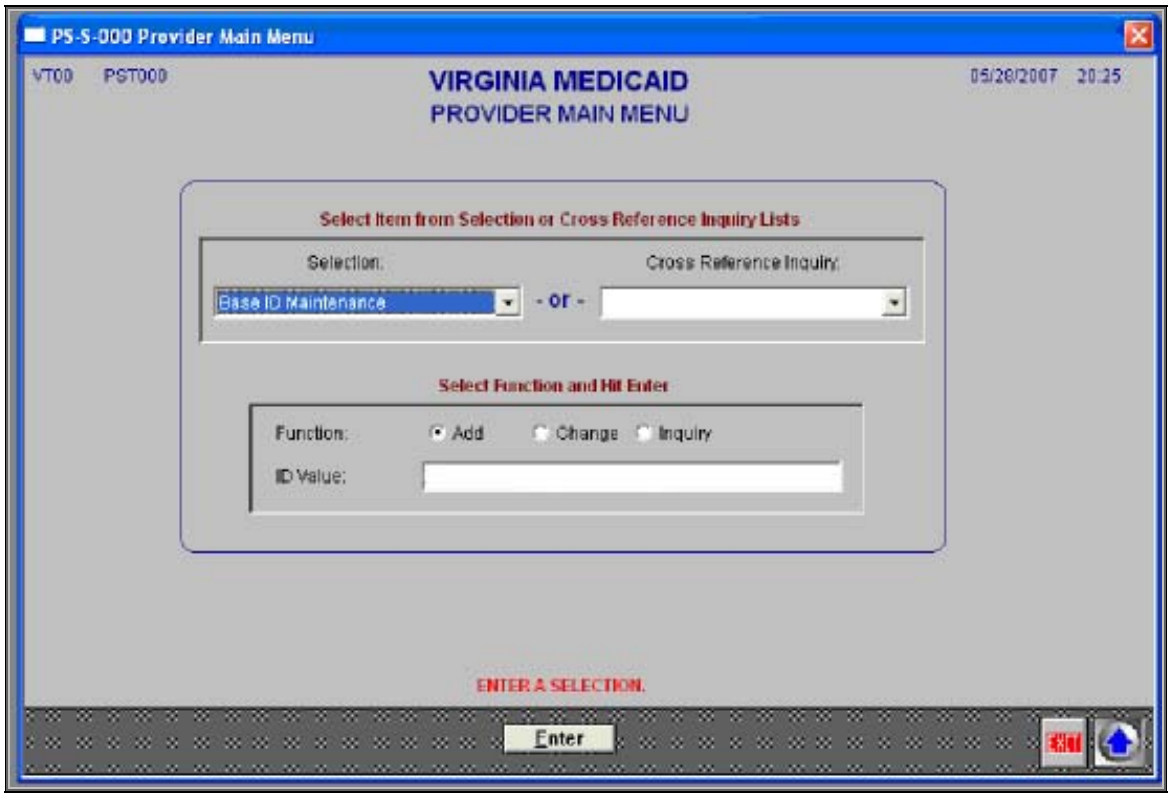
A Base ID is a unique 6-digit number assigned to each provider to associate multiple Provider ID Numbers (Legacy) with a single provider. The Base ID Maintenance screen is displayed when the user chooses the Base ID Maintenance selection from the drop-down on the Provider Menu. In addition to this selection, the user must also choose either the Add or Change function or key in a valid Provider ID into the ID Value field, and then press Enter. If a maintenance transaction already exists in the table, it will display in the maintenance line on the screen. If a maintenance transaction does not exist, blank fields are provided to key in the new values. Base ID maintenance history transactions will display at the bottom of the screen, regardless of whether an active transaction exists. History transactions were processed in batches, where active transactions have not been processed. Only one active maintenance transaction can exist for a provider each week.

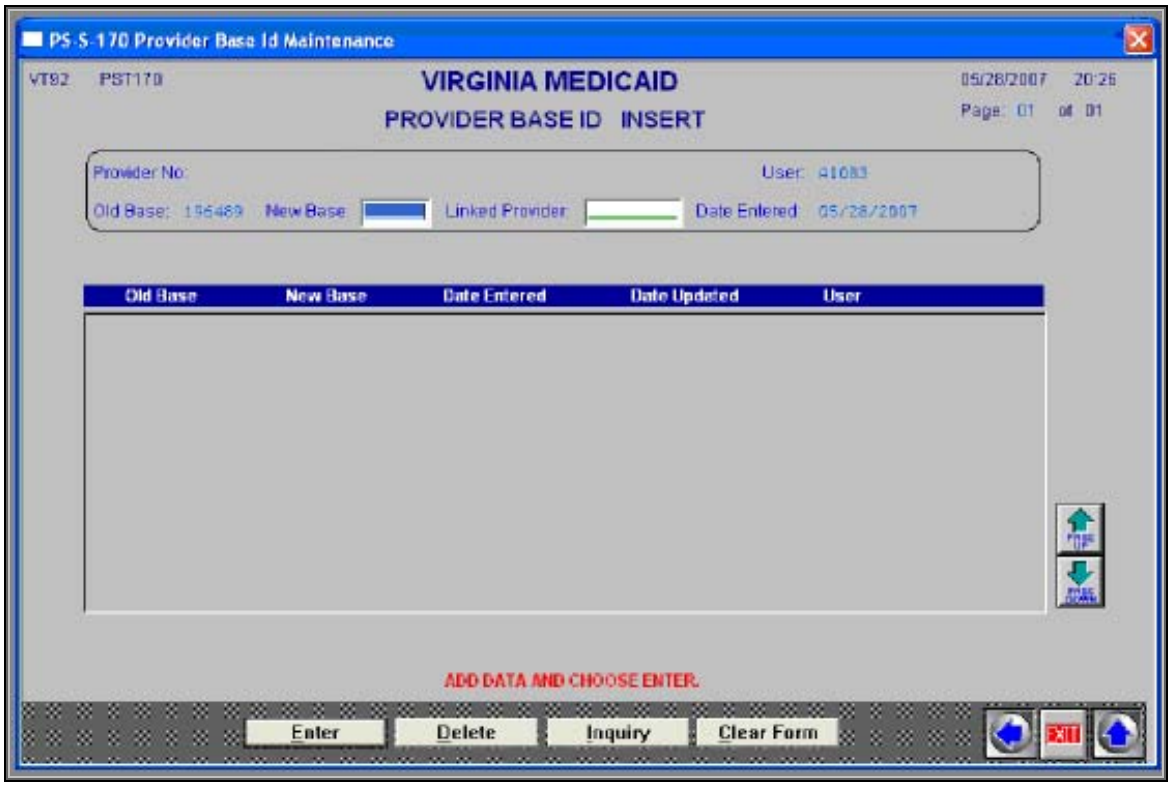
3.2 Screen Access

From the VaMMIS Main System Menu choose the Provider Sub-system:

1. On the Provider Main Menu screen, choose Base ID Maintenance from the Selection drop-down menu.
2. Select the Add or Change radio button in the Function field.
3. Enter the Provider Identification Number in the ID Value field. This must be a Legacy Provider Identification Number only.
4. Select Enter.

RF-S-010 Main System Menu
VS00 RFT010
VIRGINIA MEDICAID
MAIN SYSTEM MENU
05/28/2007 17:33
Recipient
Financial
Management & Admin Reporting
Assessments
Provider
Prior Authorization
EPSDT
Drugs
Reference
Automated Mailing
MICC
Batch On-Request Reports
Invoice Processing
Surveillance & Utilization Review
TPL Maintenance
Click Picture to Enter Subsystem
EXIT


PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
05/28/2007 20:25
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cross Reference Inquiry:
Base ID Maintenance
- or -
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION.
Enter
EXIT



3.3 Entering Provider Data

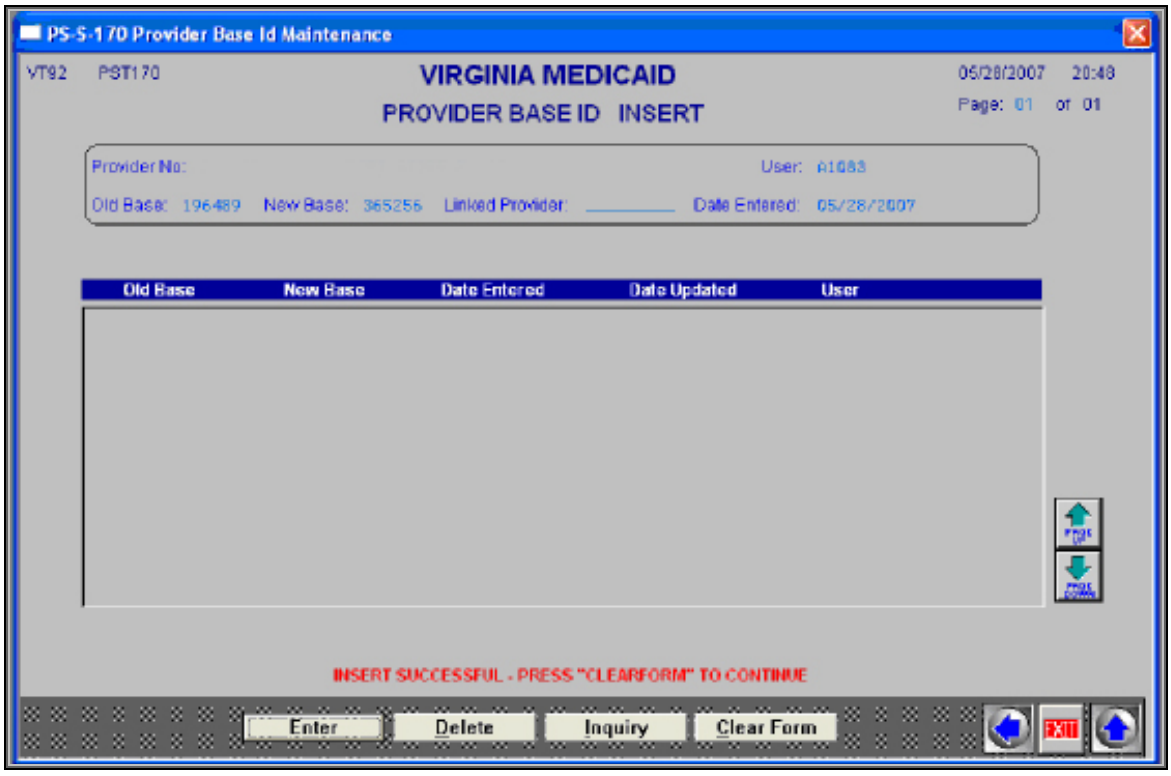
1. After all data has been entered, click Enter to view edits.
2. Correct any errors.
3. Click Update.

Screen	Data Element	Description	Value You Key	Comments
PS-S-170	Provider No	A unique 9-digit identification number assigned to the servicing or billing provider by VaMMIS (pre-NPI implementation).	N/A	System displayed. You see the Provider Identification Number entered in the ID Value field of the Provider Main Menu.
PS-S-170	Old Base	A unique 6-digit identification number previously assigned to each provider to associate multiple Provider ID Numbers with a single provider.	N/A	System displayed

Screen	Data Element	Description	Value You Key	Comments
PS-S-170	Linked Provider	The new Provider Number to be linked to the Base ID currently assigned.	ADD/UPDATE: (U/C) If you want to create a new base ID and assign this ID to multiple Provider IDS, do this: 1. Determine the lowest Provider ID for the group of providers. 2. Type the word NEW into the New Base ID field for that Provider. Then, choose Enter. 3. For all other Providers that need this same Base ID, type the word NEW into the New Base ID field and type the same lowest Provider ID into the Linked Provider field.	N/A
PS-S-170	Date Entered	The current date for ADDS or the date from the maintenance transaction for	N/A	System displayed
PS-S-170	User	The user's system identification number	N/A	System displayed
PS-S-170	Old Base	The base ID currently on the Provider database for the provider	N/A	System displayed
PS-S-170	New Base	The new base ID assigned to the Provider during a maintenance update transaction.	N/A	System displayed

Screen	Data Element	Description	Value You Key	Comments
PS-S-170	Date Entered	The date a base ID maintenance transaction was entered.	N/A	System displayed
PS-S-170	Date Updated	The date the Base ID maintenance transaction was processed in batch.	N/A	System displayed
PS-S-170	User	The user ID of the user who made the base ID maintenance change.	N/A	System displayed

Screen	Data Element	Description	Value You Key	Comments
PS-S-170	New Base	The new base ID to be assigned to the Provider number.	ADD/UPDATE: (U/C) The user has several options: 1. To assign the Provider a base ID that is already in the system: Type in the ID and choose Enter. 2. To create and assign a new base ID: Type the word NEW into this field. Then, choose Enter. 3. To create and assign a new base ID and assign it to multiple Provider IDs: Determine the lowest Provider ID for the group. Type the word NEW into the New Base ID field for that Provider. Then, choose Enter. For all other Providers that need this same Base ID, type the word NEW into the New Base ID field and type the same lowest Provider ID into the Linked Provider field.	N/A



3.4 Error Messages

Screen	Error	Description	Value You Key	Comments
PS-S-170	4056	ADD DATA AND CHOOSE ENTER	N/A	Information message
PS-S-170	71	ALREADY AT THE FIRST PAGE; CANNOT SCROLL FURTHER	N/A	Information message
PS-S-170	72	ALREADY AT THE LAST PAGE; CANNOT SCROLL FURTHER	N/A	Information message
PS-S-170	4038	BASE ID IS INVALID	N/A	Information message
PS-S-170	4159	BASE ID NOT FOUND FOR EXISTING PROVIDER	N/A	Information message

Screen	Error	Description	Value You Key	Comments
PS-S-170	8	ENTER PROVIDER NUMBER	Enter a valid Provider number. See the field definitions for formatting/ requirements for this field.	N/A
PS-S-170	15	FUNCTION CHOSEN IS INVALID	N/A	Choose another function.
PS-S-170	7009	NO DATA TO DELETE	N/A	Information message No action needed.
PS-S-170	64	NO DATA TO SCROLL	N/A	Information message No action needed.
PS-S-170	7066	NOTHING TO UPDATE; DATA HAS NOT CHANGED	N/A	Information message No action needed.
PS-S-170	4744	PROVIDER ID MUST BE NUMERIC	Enter a valid numeric, provider identification number.	N/A
PS-S-170	2076	PROVIDER NUMBER ENTERED NOT ON DATABASE	Contact First Health Operations for assistance.	N/A
PS-S-170	32	UPDATE DATA AND CHOOSE ENTER	Update data, and then choose the Enter button.	N/A

4.0 Billing Address Maintenance Screen

4.1 General Information

This screen allows a user to add and update the Provider Address data elements. Addresses include Correspondence (where the provider can request mail be sent), Pay-to (where the provider can request checks be sent), and Remittance Advice Address (where the provider can request RAs be sent) and IRS address (address where the 1099 is sent). A Correspondence Address is required for every individual provider. Pay-to and Remittance Advice Addresses are optional.

Note: If a providers' Pay-to and Remittance Advice Addresses are identical, do not enter the Remittance Advice Address, as this will cause a corresponding payment (e.g., check) and Remittance Advice to be mailed to the same address separately.

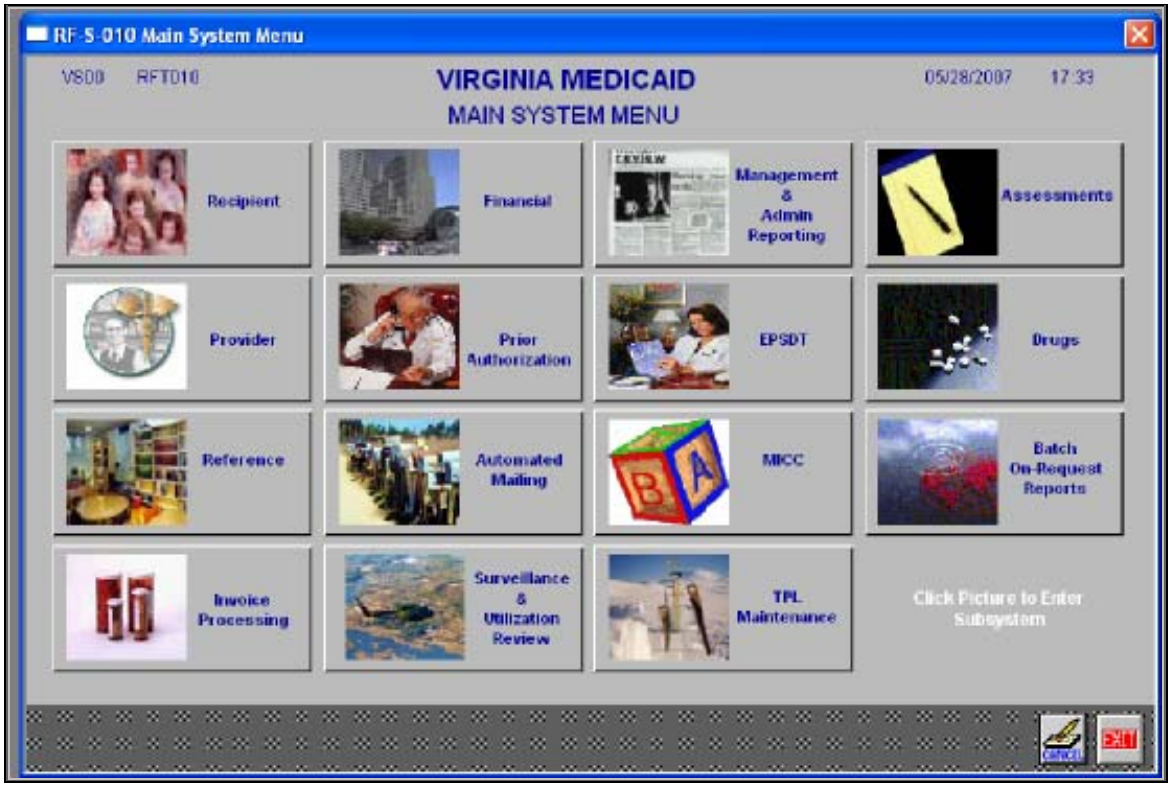
4.2 Screen Access

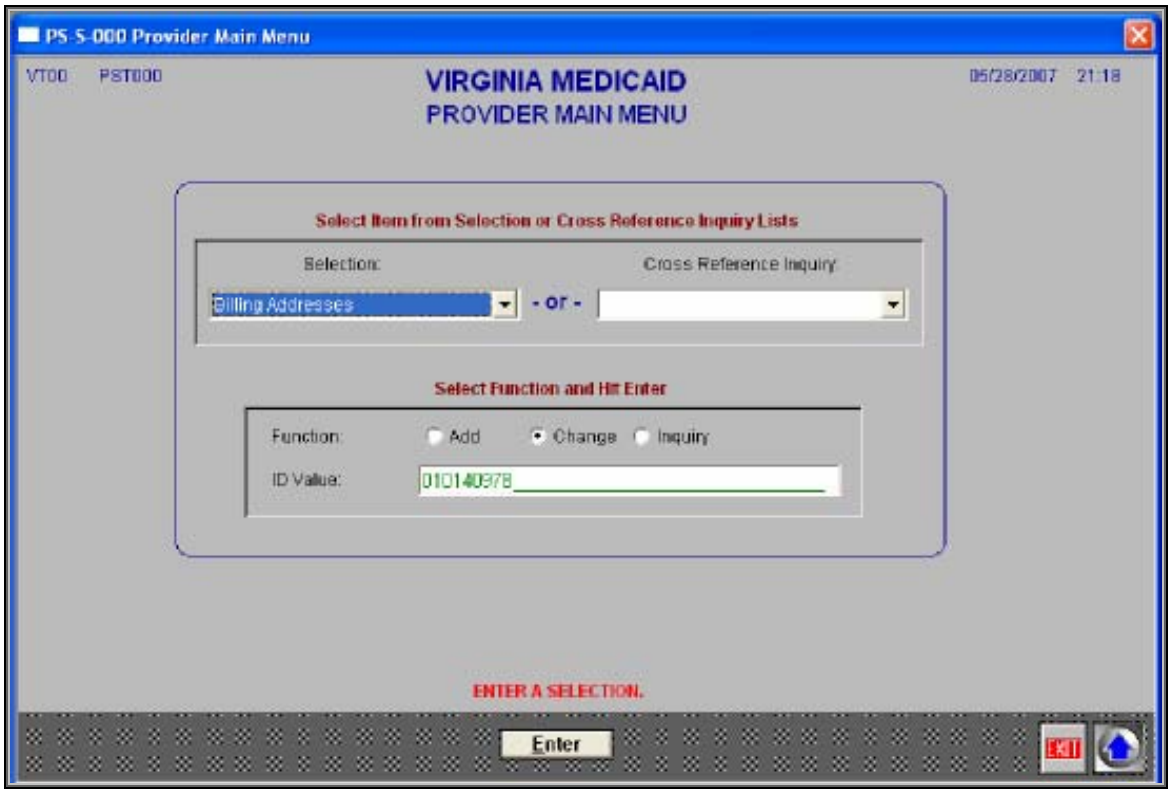
From the VaMMIS Main System Menu choose the Provider Sub-system:

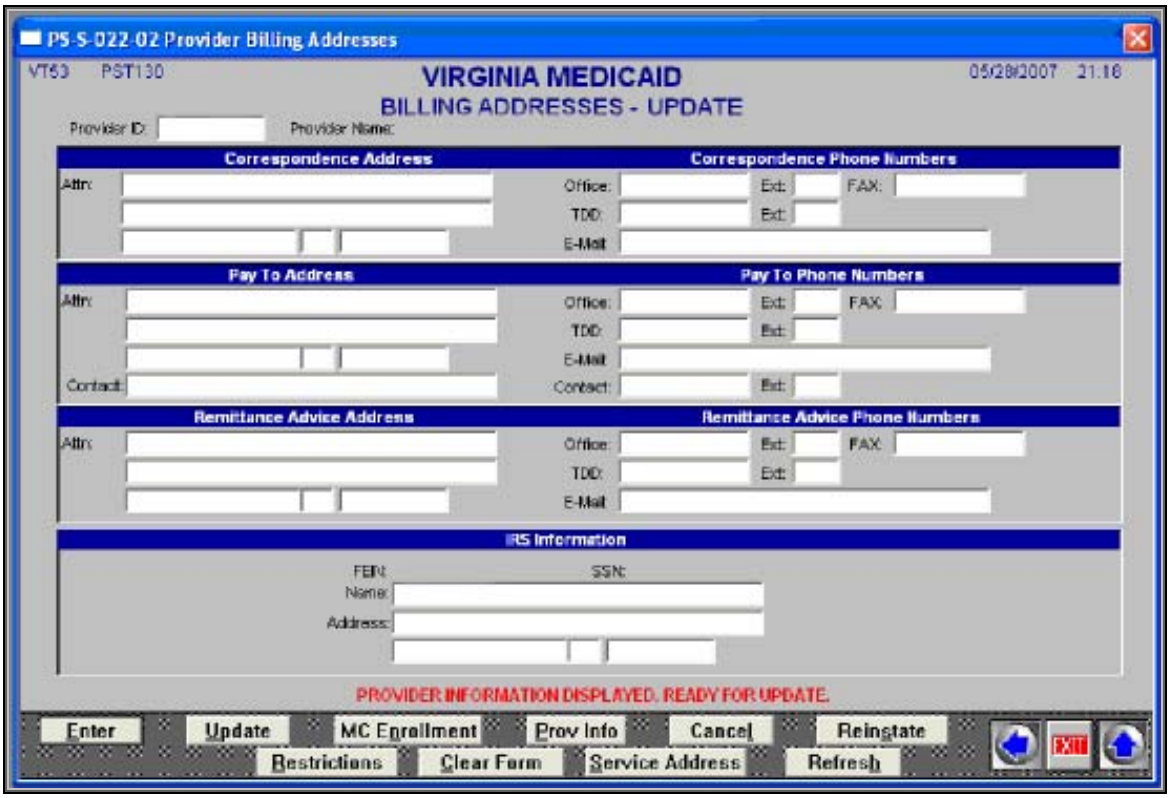
1. On the Provider Main Menu Screen, select Billing Addresses from the Selection drop-down menu.
2. Select the Add or Change radio button in the Function field.
3. Enter the Provider Identification Number in the ID Value field.

   Note: This must be a Legacy Provider Identification Number only.

4. Choose Enter.


RF-S-010 Main System Menu
VS00 RFT010
VIRGINIA MEDICAID
MAIN SYSTEM MENU
05/28/2007 17:33
Recipient
Financial
Management & Admin Reporting
Assessments
Provider
Prior Authorization
EPSDT
Drugs
Reference
Automated Mailing
MICC
Batch On-Request Reports
Invoice Processing
Surveillance & Utilization Review
TPL Maintenance
Click Picture to Enter Subsystem
CANCEL
EXIT


PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
05/28/2007 21:18
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Billing Addresses
- or -
Cross Reference Inquiry
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
0101140978
ENTER A SELECTION.
Enter
EXIT



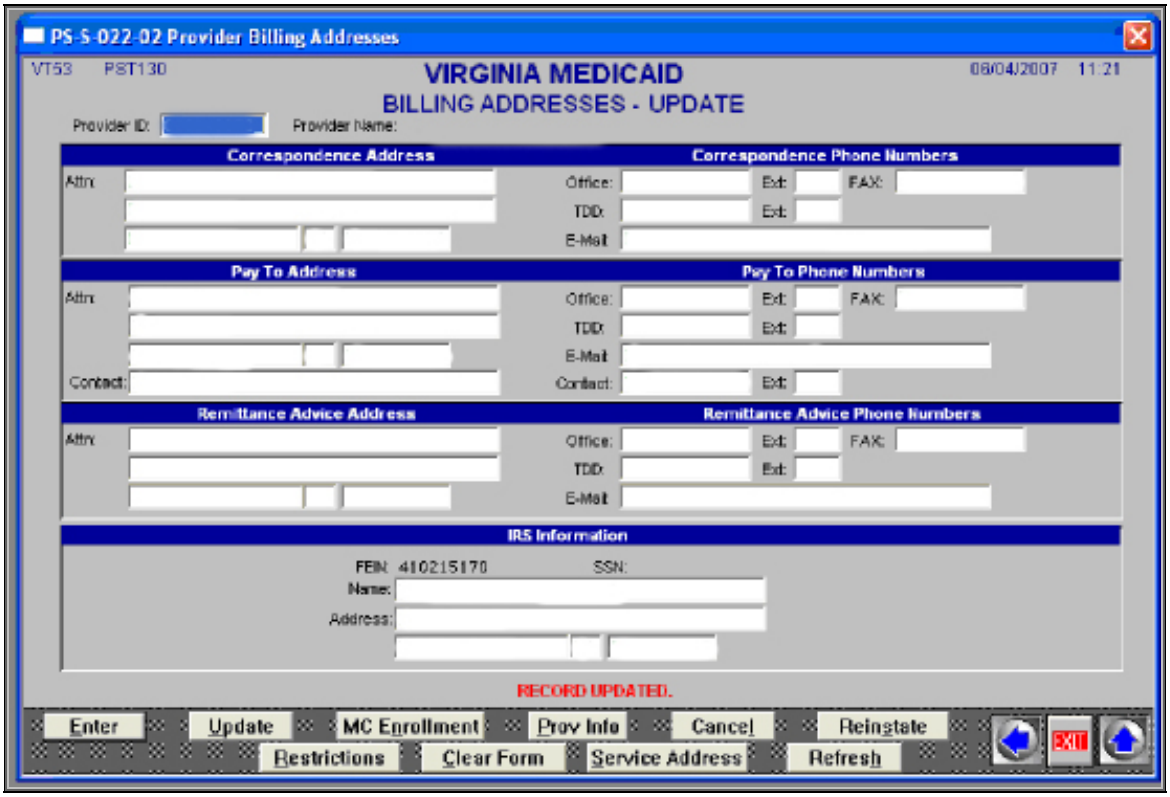
4.3 Entering Provider Data

1. After all data has been entered, click Enter to view edits.
2. Correct any errors.
3. Click Update.

Screen	Data Element	Description	Value You Key	Comments
PS-S-022-02	Provider No	A unique identification number assigned to the servicing or billing provider. Can be a NPI/API or a Legacy	Enter a valid Provider ID Number.	N/A
PS-S-022-02	Provider Name	The name of the servicing or billing Provider	N/A	System displayed
PS-S-022-02	Attn	The Attention Line in the address of the provider	Enter a valid Provider Address Additional Name.	N/A
PS-S-022-02	Provider Address Line	The delivery (street or delivery) address line of the servicing or billing provider.	Enter a valid Provider Address.	N/A

Screen	Data Element	Description	Value You Key	Comments
PS-S-022-02	City	The city delivery address line of the servicing or billing provider.	Enter a valid Provider City Delivery Address.	N/A
PS-S-022-02	State	The state delivery address line of the servicing or billing provider.	Enter a valid Provider State Delivery Address.	N/A
PS-S-022-02	Zip Code	The ZIP Code delivery address line of the servicing or billing provider.	Enter a valid Provider ZIP CODE.	N/A
PS-S-022-02	Contact	The individual person to contact at the servicing or billing location	Enter a valid Provider Contact Name.	N/A
PS-S-022-02	Office	The number indicating the phone number of the provider	Enter a valid Phone Number.	N/A
PS-S-022-02	Ext	The phone number extension for a provider	Enter a valid Provider Phone Extension Number.	When entered, must be numeric. Can be 1 to 4 positions
PS-S-022-02	Fax	The number indicating the fax phone number of the provider	Enter a valid Phone Number.	N/A
PS-S-022-02	TDD	The number indicating the TDD phone number of the provider	Enter a valid Phone Number.	N/A
PS-S-022-02	Ext	The TDD phone number extension for a provider.	Enter a valid Provider Phone Extension Number.	When entered, must be numeric. Can be 1 to 4 positions.
PS-S-022-02	Date Updated	The date the Base ID maintenance transaction was processed in batch.	N/A	N/A
PS-S-022-02	E-mail	The E-mail address of the provider	Enter a valid Provider E-mail address.	N/A
PS-S-022-02	Contact (Phone Number)	The number indicating the phone number of the contact person for the provider	Enter a valid Phone Number.	N/A

Screen	Data Element	Description	Value You Key	Comments
PS-S-022-02	Ext	The Contact phone number extension for a provider.	Enter a valid Provider Phone Extension Number.	When entered, must be numeric. Can be 1 to 4 positions
PS-S-022-02	IRS Name	The IRS name of the provider that is printed on 1099s.	Enter the provider IRS name.	N/A



4.4 Error Messages

Screen	Error	Description	Value You Key	Comments
PS-S-022-02	42	ACCESS TO THE PROGRAM IS NOT AUTHORIZED	N/A	User does not have access to the screens chosen.
PS-S-022-02	4611	CANNOT ADD OR INQUIRY ON A REINSTATE TRANSACTION	N/A	Information message

Screen	Error	Description	Value You Key	Comments
PS-S-022-02	9932	CANNOT UPDATE LEGACY ID AFTER COMPLIANCE DATE	Enter NPI instead of Legacy	N/A
PS-S-022-02	39	CHOOSE UPDATE TO SAVE CHANGES	Choose the update button to save the changes.	N/A
PS-S-022-02	46	DATA HAS CHANGED SINCE RETRIEVAL CHOOSE REFRESH TO RE-DISPLAY.	Choose the Refresh button to display current data.	N/A
PS-S-022-02	2	DATA NOT CHANGED	N/A	Information message
PS-S-022-02	68	DATA REFRESHED	N/A	Information message
PS-S-022-02	4916	DELETING REMITTANCE ADDRESS, CHOOSE UPDATE TO SAVE CHANGES	N/A	Information message
PS-S-022-02	9931	EMAIL ADDRESS IS INVALID	Enter a valid email address.	N/A
PS-S-022-02	4622	ENTER A VALID PHONE NUMBER	Enter valid values according to error message specifications.	N/A
PS-S-022-02	69	ENTER MANDATORY FIELDS	You must enter the fields to complete the task.	N/A
PS-S-022-02	4081	ENTER NUMERIC PROVIDER NUMBER	Enter valid values according to error message specifications.	N/A
PS-S-022-02	8	ENTER PROVIDER NUMBER	Enter a valid Provider number. See the field definitions for formatting/ requirements for this field.	N/A
PS-S-022-02	10	ERROR OCCURRED AT RECEIVE; TRANSACTION CANCELLED	Retry the transaction, if necessary.	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-022-02	11	ERROR OCCURRED AT SEND; TRANSACTION CANCELLED	Retry the transaction, if necessary.	N/A
PS-S-022-02	4043	EXTN IS INVALID	N/A	Information message
PS-S-022-02	15	FUNCTION CHOSEN IS INVALID	N/A	Choose another function.
PS-S-022-02	4698	INVALID ENTRY FOR SERVICING ADDRESS	Check field for valid data and re-enter.	N/A
PS-S-022-02	4093	INVALID LOCALITY CODE	Check field for valid data and re-enter.	N/A
PS-S-022-02	4044	PHONE NUMBER IS INVALID	N/A	Information message
PS-S-022-02	4498	PROVIDER ADDRESS DOES NOT EXIST	N/A	Information message
PS-S-022-02	4098	PROVIDER INFORMATION DISPLAYED	N/A	Information message
PS-S-022-02	4100	PROVIDER INFORMATION DISPLAYED READY FORUPDATE.	N/A	Information message
PS-S-022-02	6	PROVIDER NUMBER NOT FOUND	N/A	Information message
PS-S-022-02	25	RECORD UPDATED	N/A	Information message
PS-S-022-02	4349	STATE IS INVALID	N/A	Information message
PS-S-022-02	67	UNABLE TO RETURN TO PREVIOUS PROGRAM, CHOOSE THE EXIT BUTTON TO CONTINUE	Choose the EXIT button to Continue processing.	N/A
PS-S-022-02	43	UNIDENTIFIED SECURITY ERROR	N/A	User not authorized for the transaction.

Screen	Error	Description	Value You Key	Comments
PS-S-022-02	9923	UPDATING THE INFORMATION WILL UPDATE FOR ALL SHARING THE EIN	Press Update for accepting the changes or cancel to discard the changes.	N/A
PS-S-022-02	4679	ZIP CODE AND LOCALITY DO NOT MATCH	Check both the ZIP code and locality.	N/A
PS-S-022-02	4045	ZIP CODE IS INVALID	Enter a valid ZIP code. See the field definitions for explanation and formatting requirements.	N/A

5.0 Servicing Address Maintenance Screen

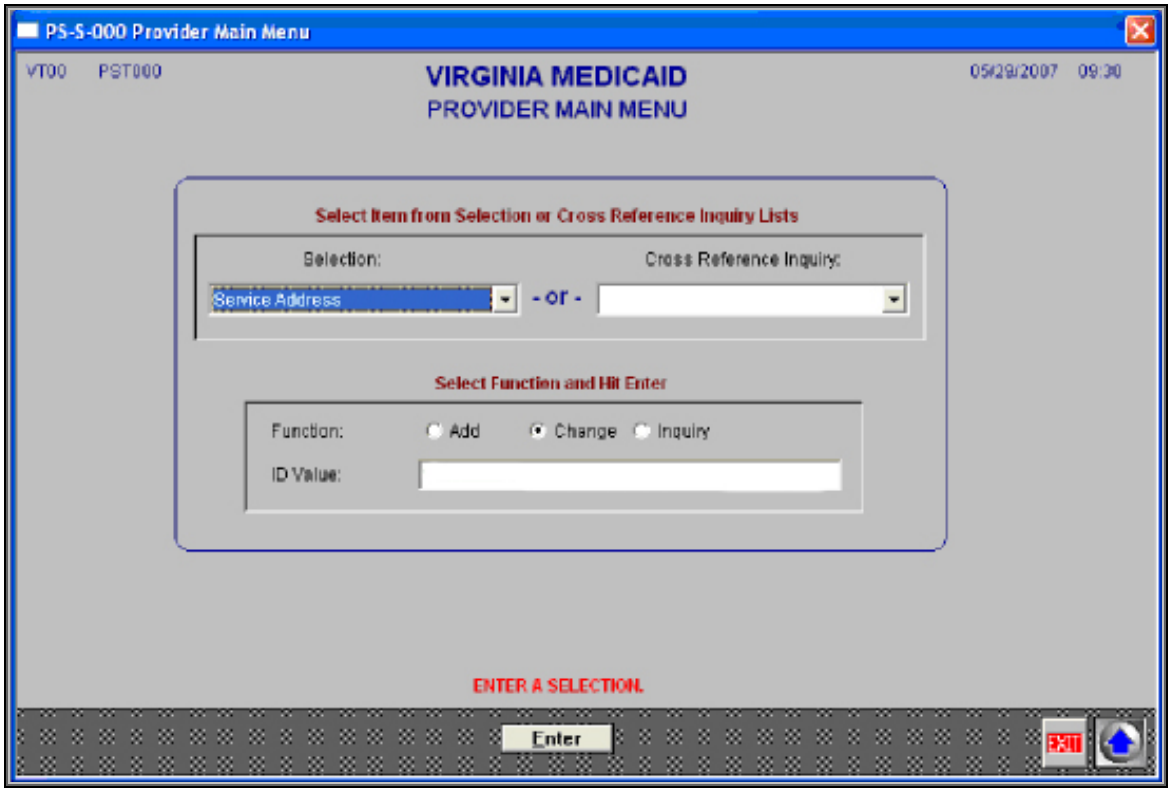
5.1 General Information

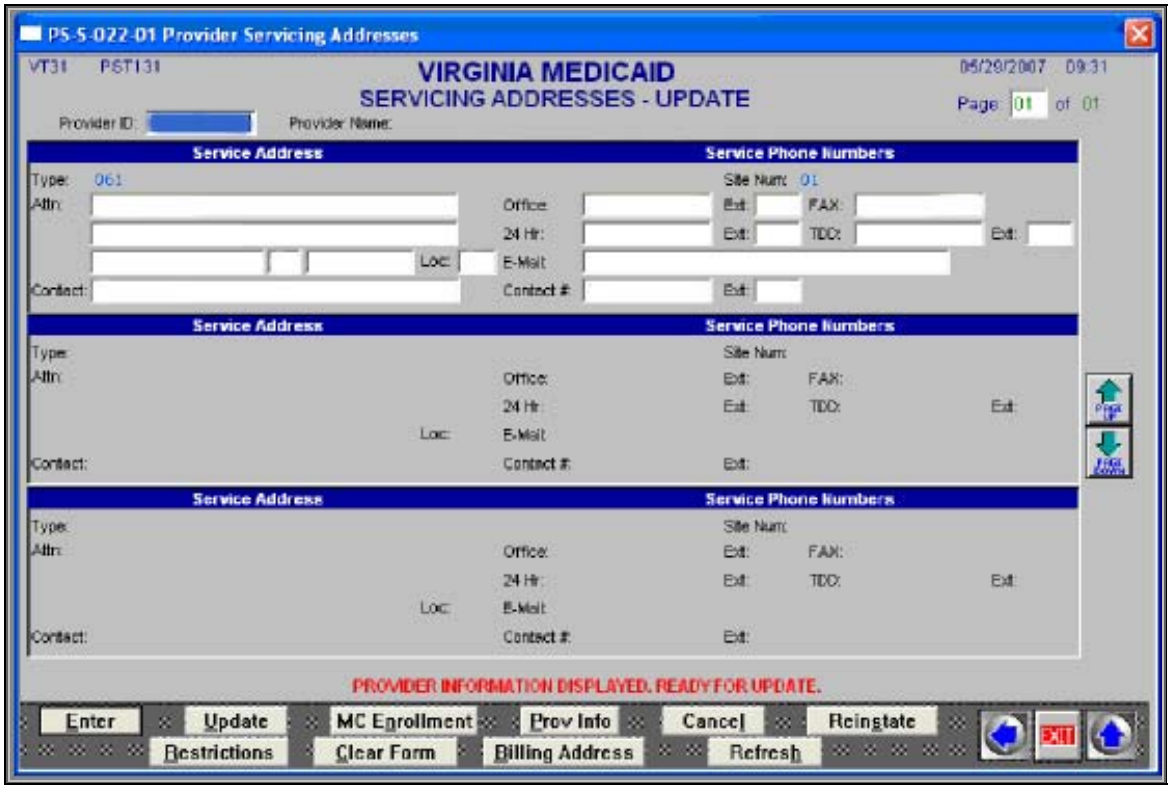
A Servicing Address is required for every individual provider. This screen allows a User to update the Provider Servicing Addresses data elements.

5.2 Screen Access

From the VaMMIS Main System Menu choose the Provider Sub-system:

1. On the Provider Main Menu Screen, select Provider Servicing Address from the Selection drop-down menu.
2. Select the Change radio button in the Function field.
3. Enter the Provider Identification Number (NPI, API, or Legacy) in the ID Value field.
4. Select Enter.


PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
05/29/2007 09:30
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cross Reference Inquiry:
Service Address
- or -
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION
Enter
EXIT


PS-S-022-01 Provider Servicing Addresses
VT31 PST131
VIRGINIA MEDICAID
SERVICING ADDRESSES - UPDATE
05/29/2007 09:31
Page 01 of 01
Provider ID:
Provider Name:
Service Address
Service Phone Numbers
Type: 061
Site Num: 01
Attn:
Office:
Ext:
FAX:
24 Hr:
TDD:
Loc:
E-Mail:
Contact:
Contact #:
PROVIDER INFORMATION DISPLAYED. READY FOR UPDATE.
Enter
Update
MC Enrollment
Prov Info
Cancel
Reinstate
Restrictions
Clear Form
Billing Address
Refresh
EXIT

5.3 Entering Provider Data

5. After all data has been entered, click Enter to view edits.
6. Correct any errors.
7. Click Update.

Screen	Data Element	Description	Value You Key	Comments
PS-S-022-01	Provider No	A unique identification number assigned to the servicing or billing provider. Can be a NPI/API or a Legacy	Enter a valid Provider ID Number.	N/A
PS-S-022-01	Provider Name	The name of the servicing or billing Provider	N/A	System displayed
PS-S-022-01	Type	A code that designates the classification of a provide	N/A	System displayed
PS-S-022-01	Site Numb	This field contains a consecutive number for each unique location an NPI Provider is using for a servicing address. An NPI may have multiple provider types share the same servicing address. They also may have multiple servicing addresses.	N/A	System displayed
PS-S-022-01	Attn	The Attention Line in the address of the provider	Enter a valid Provider Address Additional Name.	N/A
PS-S-022-01	Contact	The individual person to contact at the servicing or billing location	Enter a valid Provider Contact Name.	N/A
PS-S-022-01	Office	The number indicating the phone number of the provider	Enter a valid Phone Number.	N/A
PS-S-022-01	Ext	The phone number extension for a provider	Enter a valid Provider Phone Extension Number.	When entered, must be numeric. Can be 1 to 4 positions

Screen	Data Element	Description	Value You Key	Comments
PS-S-022-01	Fax	The number indicating the fax phone number of the provider	Enter a valid Phone Number.	N/A
PS-S-022-01	Attn	The Attention Line in the address of the provider	Enter a valid Provider Address Additional Name.	N/A
PS-S-022-01	Contact	The individual person to contact at the servicing or billing location	Enter a valid Provider Contact Name.	N/A
PS-S-022-01	TDD	The number indicating the TDD phone number of the provider	Enter a valid Phone Number.	N/A
PS-S-022-01	Ext	The TDD contact phone number extension for a provider.	Enter a valid Provider Phone Extension Number.	When entered, must be numeric. Can be 1 to 4 positions
PS-S-022-01	Contact (Phone Number)	The number indicating the phone number of the contact person for the provider	Enter a valid Phone Number.	N/A
PS-S-022-01	Ext	The contact phone number extension for a provider.	Enter a valid Provider Phone Extension Number.	When entered, must be numeric. Can be 1 to 4 positions
PS-S-022-01	Provider Address Line	The delivery (street or delivery) address line of the servicing or billing provider.	Enter a valid Provider Address.	N/A
PS-S-022-01	City	The city delivery address line of the servicing or billing provider.	Enter a valid Provider City Delivery Address.	N/A
PS-S-022-01	State	The state delivery address line of the servicing or billing provider.	Enter a valid Provider State Delivery Address.	N/A
PS-S-022-01	Zip Code	The ZIP Code delivery address line of the servicing or billing provider.	Enter a valid Provider ZIP CODE.	N/A

Screen	Data Element	Description	Value You Key	Comments
PS-S-022-01	E-mail	The E-mail address of the provider	Enter a valid Provider E-mail address.	N/A
PS-S-022-01	Location Code	The location code for the county in which a provider is located	Enter a valid location code.	The location code depends on the zip code. Use Power Zip software to calculate the zip code.

5.4 Error Messages

Screen	Error	Description	Value You Key	Comments
PS-S-022-01	42	ACCESS TO THE PROGRAM IS NOT AUTHORIZED	User does not have access to the screens chosen.	User does not have access to the screens chosen.
PS-S-022-01	71	ALREADY AT THE FIRST PAGE; CANNOT SCROLL FURTHER	Information message	Information message
PS-S-022-01	72	ALREADY AT THE LAST PAGE; CANNOT SCROLL FURTHER	Information message	N/A
PS-S-022-01	4611	CANNOT ADD OR INQUIRY ON A REINSTATE TRANSACTION	Information message	N/A
PS-S-022-01	9932	CANNOT UPDATE LEGACY ID AFTER COMPLIANCE DATE	Enter NPI instead of Legacy	N/A
PS-S-022-01	9865	CHOOSE ENTER TO DISPLAY	Information message	Information message
PS-S-022-01	39	CHOOSE UPDATE TO SAVE CHANGES	Choose the update button to save the changes.	Information message
PS-S-022-01	46	DATA HAS CHANGED SINCE RETRIEVAL CHOOSE REFRESH TO RE-DISPLAY.	Choose the Refresh button to display current data.	Information message
PS-S-022-01	2	DATA NOT CHANGED	Information message No action needed.	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-022-01	68	DATA REFRESHED	Information message	N/A
PS-S-022-01	9931	EMAIL ADDRESS IS INVALID	Enter a valid email address.	N/A
PS-S-022-01	4622	ENTER A VALID PHONE NUMBER		N/A
PS-S-022-01	69	ENTER MANDATORY FIELDS	You must enter the fields to complete the task.	N/A
PS-S-022-01	4081	ENTER NUMERIC PROVIDER NUMBER	Enter valid values according to error message specifications.	N/A
PS-S-022-01	8	ENTER PROVIDER NUMBER	Enter a valid Provider number. See the field definitions for formatting/ requirements for this field.	N/A
PS-S-022-01	10	ERROR OCCURRED AT RECEIVE; TRANSACTION CANCELLED	Retry the transaction, if necessary.	Information message
PS-S-022-01	11	ERROR OCCURRED AT SEND; TRANSACTION CANCELLED	Retry the transaction, if necessary.	Choose another function
PS-S-022-01	4043	EXTN IS INVALID	Information message	N/A
PS-S-022-01	15	FUNCTION CHOSEN IS INVALID	Choose another function.	N/A
PS-S-022-01	4698	INVALID ENTRY FOR SERVICING ADDRESS	Check field for valid data and re-enter.	Information message
PS-S-022-01	4093	INVALID LOCALITY CODE	Check field for valid data and re-enter.	Information message
PS-S-022-01	4044	PHONE NUMBER IS INVALID	Information message	Information message
PS-S-022-01	9919	PLEASE ENTER THE NPI/API OF THE PROVIDER	Use the NPI/API of the provider instead.	Information message
PS-S-022-01	4498	PROVIDER ADDRESS DOES NOT EXIST	Information message	Information message
PS-S-022-01	4098	PROVIDER INFORMATION DISPLAYED	Information message	Information message

Screen	Error	Description	Value You Key	Comments
PS-S-022-01	4100	PROVIDER INFORMATION DISPLAYED READY FOR UPDATE.		Information message
PS-S-022-01	6	PROVIDER NUMBER NOT FOUND	Information message No action needed.	N/A
PS-S-022-01	25	RECORD UPDATED	Information message No action needed.	User not authorized for the transaction.
PS-S-022-01	4349	STATE IS INVALID	Information message	N/A
PS-S-022-01	67	UNABLE TO RETURN TO PREVIOUS PROGRAM, CHOOSE THE EXIT BUTTON TO CONTINUE	Choose the EXIT button to continue processing.	N/A
PS-S-022-01	43	UNIDENTIFIED SECURITY ERROR	User not authorized for the transaction.	N/A
PS-S-022-01	4679	ZIP CODE AND LOCALITY DO NOT MATCH	Check both the ZIP code and locality.	

6.0 Group / Provider Maintenance Screen

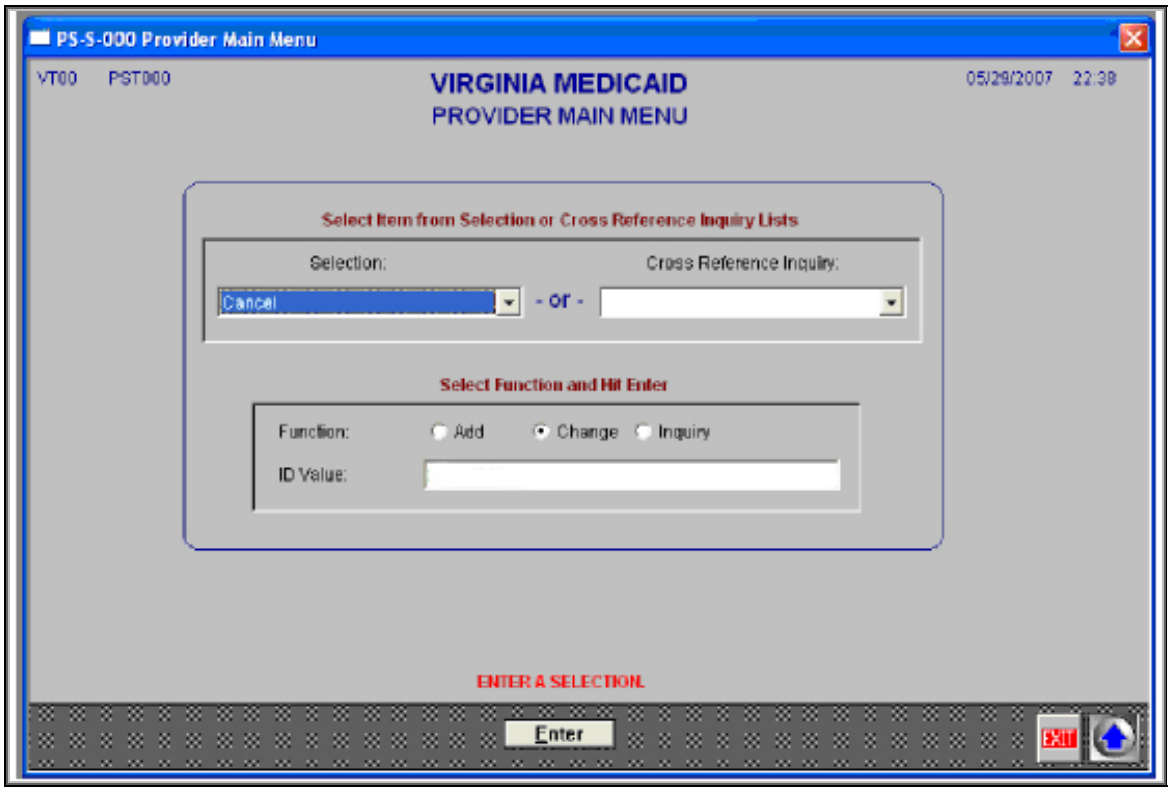
6.1 General Information

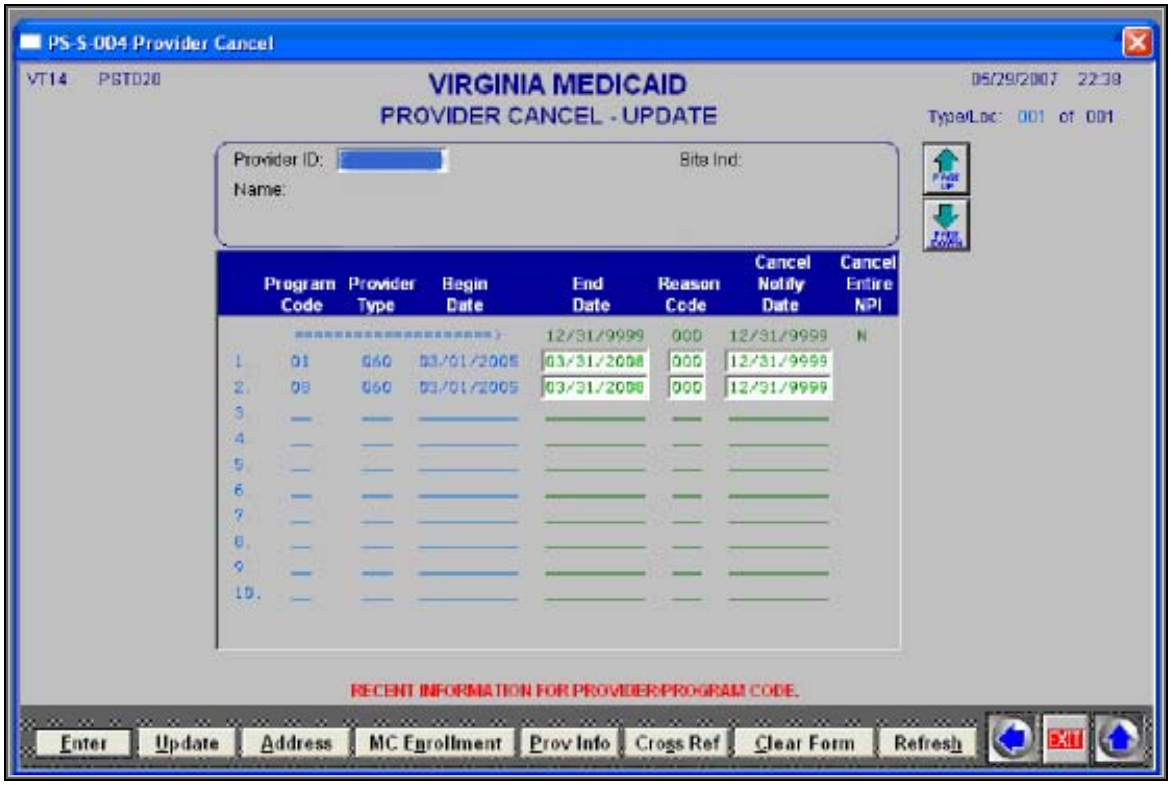
This screen allows the immediate online cancellation of an active provider. The cancel date may be the current or future date. A cancel letter will be generated when the Provider is canceled informing the provider of the cancellation in the specific and/or all Medicaid programs with a reason and the date of the cancellation. To cancel the program(s) of a provider, type over the End Date of the record(s), type over the Reason Code, and choose Enter. If no errors occur, choose Update at the bottom of the screen to post the entry to the database.

6.2 Screen Access

From the VaMMIS Main System Menu choose the Provider Sub-system:

1. On the Provider Main Menu Screen, select Cancel from the Selection drop-down menu.
2. Select the Change radio button in the Function field.
3. Enter the Provider Identification Number in the ID Value field.
4. Select Enter.


PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
05/29/2007 22:39
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cross Reference Inquiry:
Cancel
- or -
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION
Enter
EXIT


PS-S-004 Provider Cancel
VT14 PST020
VIRGINIA MEDICAID
PROVIDER CANCEL - UPDATE
05/29/2007 22:39
Type/Loc: 001 of 001
Provider ID:
Site Ind:
Name:
Program Code
Provider Type
Begin Date
End Date
Reason Code
Cancel Notify Date
Cancel Entire NPI
12/31/9999
000
12/31/9999
N
1. 01 060 03/01/2005 03/31/2008 000 12/31/9999
2. 09 060 03/01/2005 03/31/2008 000 12/31/9999
RECENT INFORMATION FOR PROVIDER/PROGRAM CODE.
Enter
Update
Address
MC Enrollment
Prov Info
Cross Ref
Clear Form
Refresh
EXIT

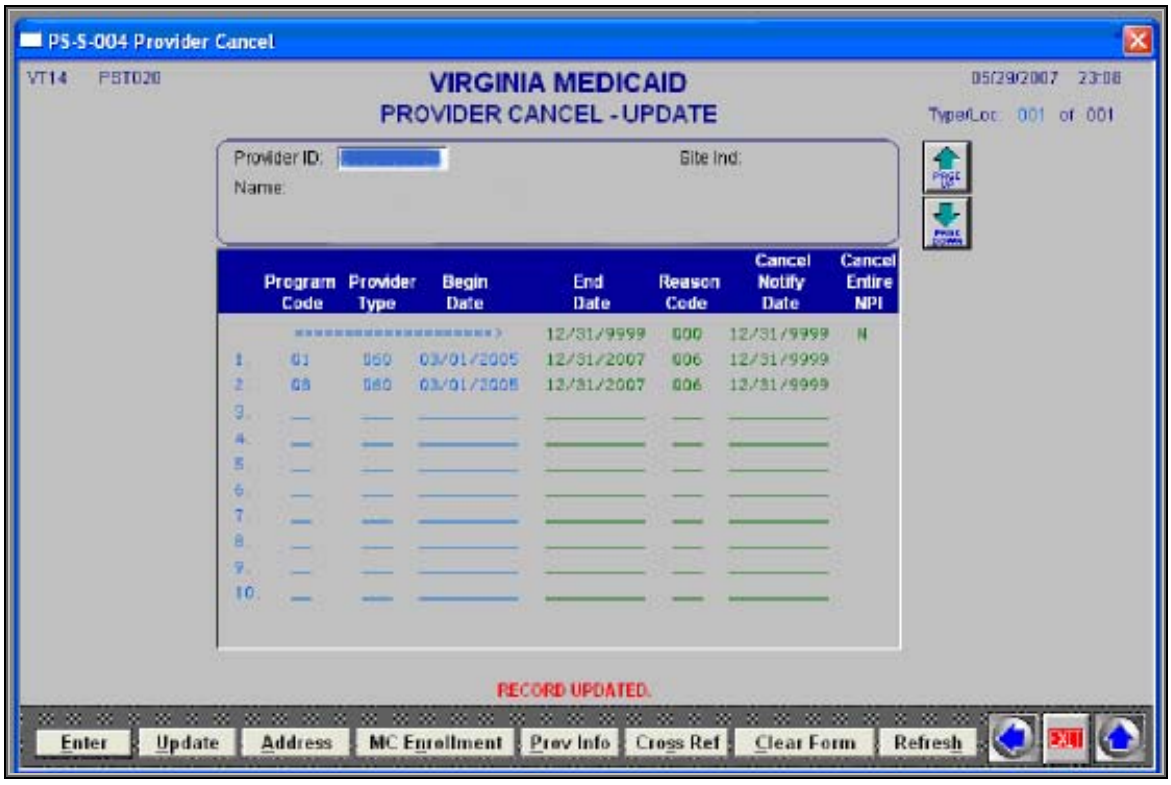
6.3 Entering Provider Data

1. After all data has been entered, click **Enter** to view edits.
2. Correct any errors.
3. Click **Update**.

Screen	Data Element	Description	Value You Key	Comments
PS-S-004	Provider ID	A unique identification number assigned to the servicing or billing provider. Can be a NPI/API or a Legacy	Enter a valid Provider ID Number.	N/A
PS-S-004	Provider Name	The name of the servicing or billing provider	N/A	System displayed
PS-S-004	Program Code	A code identifying the Program of a Provider under the State Plan. Use the Online HELP system to find valid codes for this field.	N/A	System displayed If Program 01 (Medicaid) is cancelled, all other all programs except 08 (TDO – Temporary Detention Order) will be cancelled as well.
PS-S-004	Provider Type	A code that designates the classification of a provider under the State plan	N/A	System displayed
PS-S-004	Begin Date	The date on which the Provider Program Code begins: MM/DD/CCYY format.	N/A	System displayed

Screen	Data Element	Description	Value You Key	Comments
PS-S-004	End Date	The date on which the Provider Program Code ends; MM/DD/CCYY format	Enter a valid date.	Must be a valid date, cannot be less than Provider Program Code Begin Date and must be at least 30 day after the Provider Cancellation Notification Date.
PS-S-004	Reason Code	A code identifying the Provider Cancel Reason Code of the provider's eligibility	Enter a valid Provider Cancel Reason Code.	Use the Online HELP system to find valid codes for this field.
PS-S-004	Cancel Notify Date	When a Cancel Reason Code is entered for a Provider, a Cancel Letter will be sent to the Provider that day stating that the Provider will be cancelled effective as of the Cancel Begin Date entered on the Cancel Screen.	Enter a valid Cancel Notification Begin Date.	This field is optional. If entered, must be a valid date. The user may enter the date that he cancelled the Provider. Must be greater than the Provider Program Code Begin Date. Can be up to one (1) month greater than the Provider Cancel End Date. If a date not is entered, system will default to current date.
PS-S-004	Cancel Entire NPI	Must be a "Y" or "N". "Y" means cancel all programs for every Provider Number who has the NPI number entered. "N" means no action will occur.	Must be a "Y" or "N". "Y" means cancel all programs for every Provider Number who has the NPI number entered. "N" means no action will occur.	This field can only be used when a NPI number is entered into the PROV ID field.

Screen	Data Element	Description	Value You Key	Comments
PS-S-004	Site Ind.	This field contains a consecutive number for each unique location an NPI or API provider is using for a servicing address. An NPI or API may have multiple provider types that share the same servicing address. They also may have multiple servicing addresses.	N/A	System displayed
PS-S-004	Provider Address Line	The address of the provider	N/A	System displayed
PS-S-004	Provider Address City	The city in the address for the provider	N/A	System displayed
PS-S-004	Provider Address State	The state in the address of the provider	N/A	System displayed
PS-S-004	Provider Address Zip Code	The ZIP code in the address of the provider	N/A	System displayed
PS-S-004	Type/Location Number	Total Type/Location number of the Provider	N/A	System displayed



6.4 Error Messages

Screen	Error	Description	Value You Key	Comments
PS-S-004	42	ACCESS TO THE PROGRAM IS NOT AUTHORIZED	N/A	User does not have access to the screens chosen.
PS-S-004	4408	ACTIVE PROVIDER; REINSTATE NOT ALLOWED	N/A	Information message
PS-S-004	4654	ALL PROGRAMS EXCEPT 08 FOR THE BASE WILL BE CLOSED CHOOSE UPDATE	N/A	Information message
PS-S-004	4653	ALL PROGRAMS EXCEPT 08 WILL BE CLOSED CHOOSE UPDATE.	N/A	Information message
PS-S-004	4159	BASE ID NOT FOUND FOR EXISTING PROVIDER	N/A	Information message

Screen	Error	Description	Value You Key	Comments
PS-S-004	13	BEGIN DATE IS INVALID	Enter a valid Begin date. See the Online HELP system for valid formatting/date range.	N/A
PS-S-004	4397	BEGIN DATE MUST BE GREATER THAN PREVIOUS END DATE	Enter a Begin date falling after the Previous End date.	N/A
PS-S-004	4425	BEGIN DATE MUST BE LESS THAN THE CURRENT DATE	Enter a valid Begin date.	N/A
PS-S-004	4400	CANCEL DATE IS INVALID	Enter a valid Cancel date.	N/A
PS-S-004	4403	CANCEL DATE MUST BE GREATER THAN BEGIN DATE	Enter a Cancel date falling after Current date.	N/A
PS-S-004	4395	CANCEL ENTIRE NPI MUST BE "Y" OR "N"	Change the data specified.	N/A
PS-S-004	4617	CANCEL REASON CODE '009' IS FOR AUTOMATIC CANCEL ONLY	N/A	Information message
PS-S-004	4655	CANCELING MEDICAID PROGRAM UNABLE TO CANCEL OTHER PROGRAMS	N/A	Information message
PS-S-004	39	CHOOSE UPDATE TO SAVE CHANGES	Choose the update button to save the changes.	N/A
PS-S-004	2	DATA NOT CHANGED	N/A	Information message
PS-S-004	68	DATA REFRESHED	N/A	Information message
PS-S-004	4527	DATE CONFLICT WITH APPLY TO BASE PROVIDER RECORD UPDATED.	N/A	Information message
PS-S-004	14	END DATE IS INVALID	Choose another function. See the Online HELP system for valid formatting/date range.	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-004	4401	END DATE MUST BE AT LEAST 30 DAYS AFTER CANCEL DATE	Enter a valid End date.	N/A
PS-S-004	5	END DATE MUST BE GREATER THAN BEGIN DATE	Enter an End Date that falls after the begin date. See the field definitions for valid end/begin date specifications.	N/A
PS-S-004	4081	ENTER NUMERIC PROVIDER NUMBER	Enter valid values according to error message specifications.	N/A
PS-S-004	4406	ERROR WHEN READING THE FILE	N/A	Information message
PS-S-004	4407	ERROR WHEN UPDATING THE FILE	N/A	Information message
PS-S-004	4669	ERROR WHILE CALLING CPD200 PROGRAM	N/A	Information message
PS-S-004	4668	ERROR WHILE WRITING TO CPF015 FILE	N/A	Information message
PS-S-004	4552	ESTABLISH TAX GROUP RELATIONSHIP BEFORE REINSTATING THE PROVIDER	N/A	Information message
PS-S-004	5022	FIRST RECORD IS ALREADY BEING DISPLAYED	N/A	Information message
PS-S-004	4396	FORM INDICATOR MUST BE '0', '1', '2', '3', OR '4'	N/A	Information message
PS-S-004	15	FUNCTION CHOSEN IS INVALID	N/A	Information message
PS-S-004	5023	LAST RECORD IS ALREADY BEING DISPLAYED	N/A	Information message
PS-S-004	4476	PROVIDER CANCELLED; CANCEL NOT ALLOWED	N/A	Information message
PS-S-004	22	PROVIDER NAME NOT FOUND	N/A	Information message

Screen	Error	Description	Value You Key	Comments
PS-S-004	16	PROVIDER NUMBER IS INVALID	Correct field value if keyed incorrectly. Otherwise, accept transaction with errors to generate TAD.	
PS-S-004	4258	PROVIDER PROGRAM END DATE MUST BE GREATER THAN BEGIN DATE	N/A	Information message
PS-S-004	4663	PROVIDER PROGRAM END DATE SHOULD BE CHANGED WHEN REASON CODE CHANGED	N/A	Information message
PS-S-004	4399	REASON CODE CANNOT BE '000' FOR CANCEL	N/A	Information message
PS-S-004	4398	REASON CODE CANNOT BE '000' FOR PAST END DATE	N/A	Information message
PS-S-004	4021	REASON CODE IS INVALID	Enter a valid Reason Code. See the field definitions for formatting and requirements for this field.	N/A
PS-S-004	4008	RECENT INFORMATION FOR PROVIDER/PROGRAM CODE	N/A	Information message
PS-S-004	4404	RECORD ALREADY CANCELLED	N/A	Information message
PS-S-004	24	RECORD FOR UPDATE NOT FOUND	N/A	Information message
PS-S-004	25	RECORD UPDATED	N/A	Information message

7.0 Provider / Group Maintenance Screen

7.1 General Information

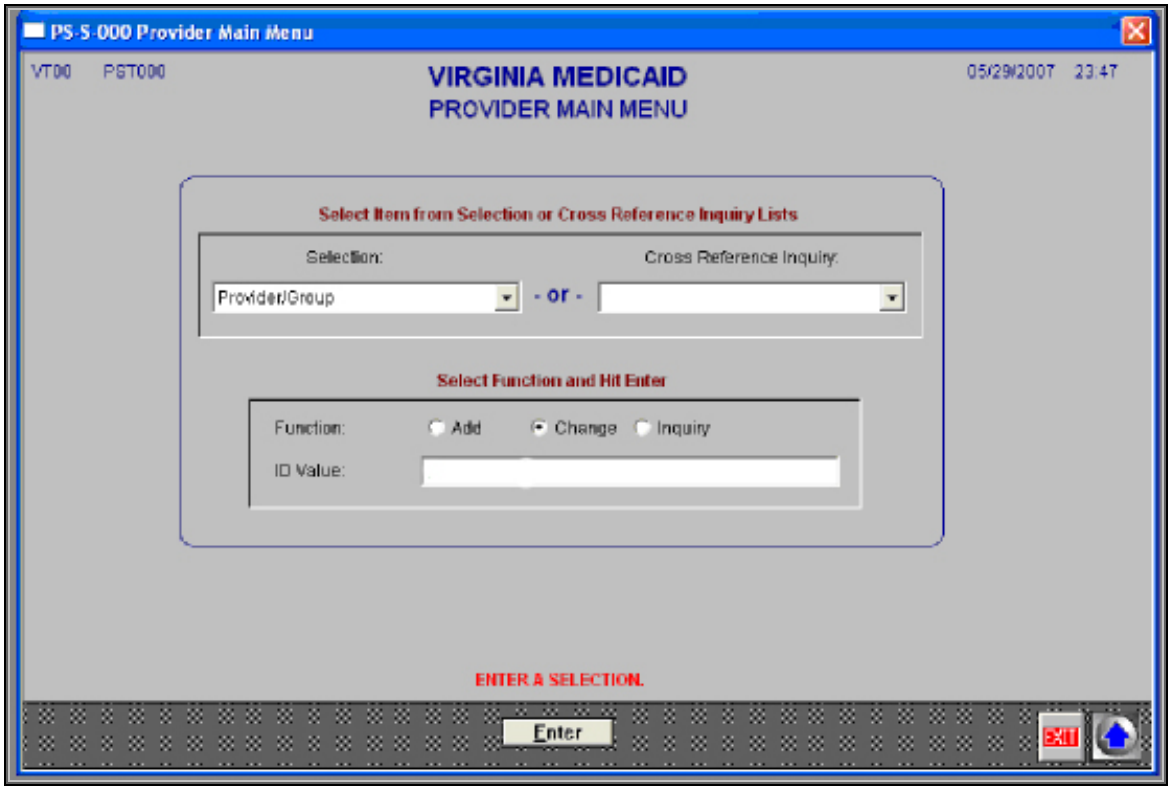
This screen allows the immediate online cancellation of an active provider. The cancel date may be the current or future date. A cancel letter will be generated when the Provider is canceled informing the provider of the cancellation in the specific and/or all Medicaid programs with a reason and the date of the cancellation. To cancel the program(s) of a provider, type over the End Date of the record(s), type over the Reason Code and choose Enter. If no errors occur, choose Update at the bottom of the screen to post the entry to the database.

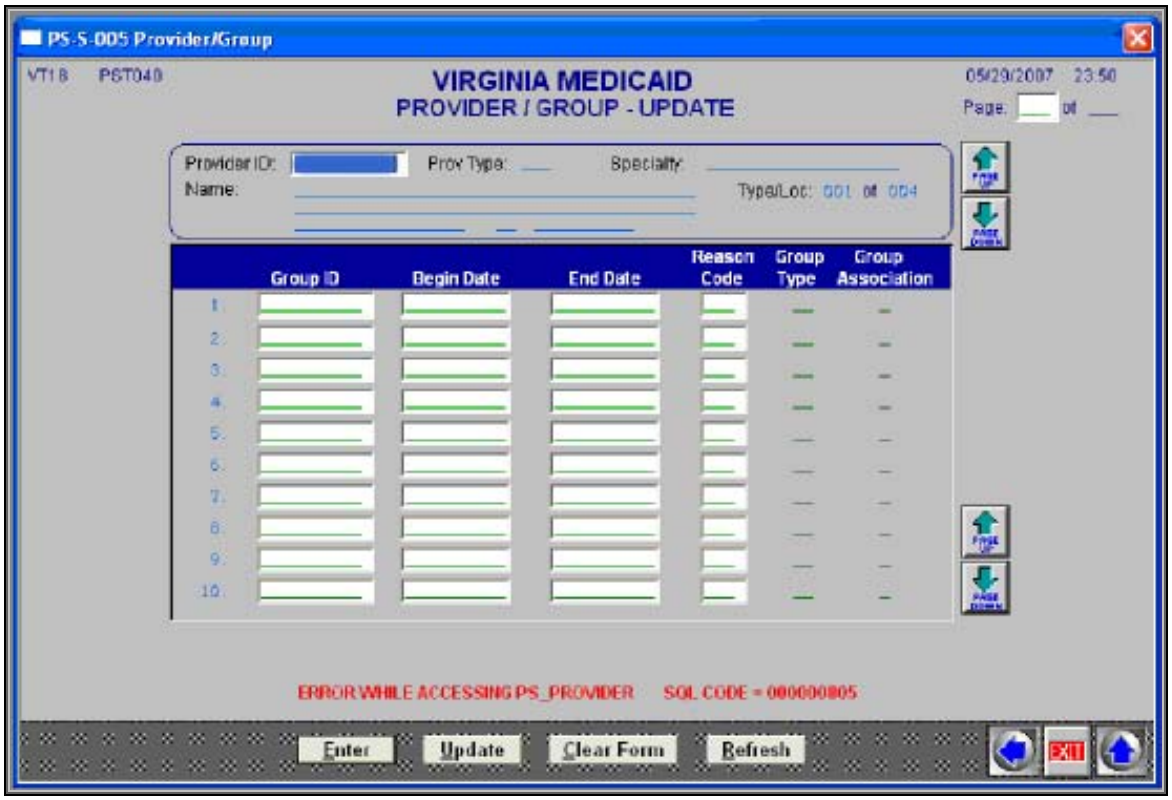
7.2 Screen Access

From the VaMMIS Main System Menu choose the Provider Sub-system:

1. On the Provider Main Menu Screen, select **Provider/Group** from the **Selection** drop-down menu.
2. Select the **Add** or **Change** radio button in the **Function** field.
3. Enter the Provider Identification Number in the **ID Value** field.
4. Select **Enter**.

RF-S-010 Main System Menu
VS00 RFT010
VIRGINIA MEDICAID
MAIN SYSTEM MENU
05/28/2007 17:33
Recipient
Financial
Management & Admin Reporting
Assessments
Provider
Prior Authorization
EPSDT
Drugs
Reference
Automated Mailing
MICC
Batch On-Request Reports
Invoice Processing
Surveillance & Utilization Review
TPL Maintenance
Click Picture to Enter Subsystem
EXIT


PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
05/29/2007 23:47
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cross Reference Inquiry:
Provider/Group
- or -
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION.
Enter
EXIT



7.3 Entering Provider Data

1. After all data has been entered, click **Enter** to view edits.
2. Correct any errors.
3. Click **Update**.

Screen	Data Element	Description	Value You Key	Comments
PS-S-005	Provider ID	A unique identification number assigned to the servicing or billing provider. Can be a NPI or a Legacy	Enter a valid Provider ID Number.	N/A
PS-S-005	Provider Type	A code that designates the classification of a provider under the State plan	N/A	System displayed
PS-S-005	Specialty	The provider's certified medical specialty(ies)	N/A	System displayed
PS-S-005	Provider Name	The name of the servicing or billing provider	N/A	System displayed

Screen	Data Element	Description	Value You Key	Comments
PS-S-005	Provider Address Line	The address of the provider	N/A	System displayed
PS-S-005	Provider Address City	The city in the address for the provider	N/A	System displayed
PS-S-005	Provider Address State	The state in the address of the provider	N/A	System displayed
PS-S-005	Provider Address Zip Code	The ZIP code in the address of the provider	N/A	System displayed
PS-S-005	Type/Location Number	Total Type/Location number of the Provider	N/A	System displayed
PS-S-005	Group ID	These are the Groups that this Provider is a participant of	Enter the Group Provider Number of the group to which the individual provider is being added	The unique provider identification number assigned to a group. The group number displayed identifies the group(s) to which the individual is assigned
PS-S-005	Begin Date	The date on which the individual Provider Group participation begins: MM/DD/CCYY format.	Enter a valid Provider Group Begin Date.	Must be greater than the previous Provider Group End Date. If a date is not entered, system will default to current date.
PS-S-005	End Date	The date on which the individual Provider Group participation ends: MM/DD/CCYY format.	Enter a valid Provider Group End Date.	Must be greater than the Provider Group Begin Date. If a date is not entered, the system will default to 12/31 /9999.
PS-S-005	Reason Code	A code identifying the Provider Group Reason Code for the provider's eligibility	Enter a valid Provider Group Reason Code.	Use the Online HELP system to find valid codes for this field.

Screen	Data Element	Description	Value You Key	Comments
PS-S-005	Group Type	A code identifying the type of group in which a provider belongs.	Enter a valid Provider Group Type.	Must be 01 Group only
PS-S-005	Group Association	A code indicating whether a provider is a Primary Care Physician within a group practice or HMO	N/A	Must be blank when Group Type is 01. System displayed.

7.4 Error Messages

Screen	Error	Description	Value You Key	Comments
PS-S-005	9921	ALREADY AT FIRST LOCATION	N/A	Information message
PS-S-005	9922	ALREADY AT LAST LOCATION	N/A	Information message
PS-S-005	4530	ASSIGN GROUP TYPE '03' ON AFFILIATION SCREEN	N/A	Information message
PS-S-005	13	BEGIN DATE IS INVALID	Enter a valid Begin date. See the Online HELP system for valid formatting/date range.	N/A
PS-S-005	1	BEGIN DATE MUST BE LESS THAN END DATE	Correct field value if keyed incorrectly. Otherwise, accept transaction with errors to generate TAD.	N/A
PS-S-005	4496	CANNOT ADD NEW BEGIN DATE LESS THAN ACTIVE BEGIN DATE	N/A	Information message
PS-S-005	9932	CANNOT UPDATE LEGACY ID AFTER COMPLIANCE DATE	Enter NPI instead of Legacy	N/A
PS-S-005	39	CHOOSE UPDATE TO SAVE CHANGES	Choose the update button to save the changes.	N/A
PS-S-005	70	CURRENT PAGE NUMBER IS	N/A	Information message

Screen	Error	Description	Value You Key	Comments
PS-S-005	46	DATA HAS CHANGED SINCE RETRIEVAL CHOOSE REFRESH TO RE-DISPLAY.	Choose the Refresh button to display current data.	N/A
PS-S-005	4475	DATE CHANGE CAUSES OVERLAP WITH ANOTHER RECORD	N/A	Information message
PS-S-005	9928	DB2 ERROR IN PSXREFVA	Contact First Health Services	Information message
PS-S-005	14	END DATE IS INVALID	Choose another function. See the Online HELP system for valid formatting/date range.	N/A
PS-S-005	4	END OF THE PAGE	N/A	Information message
PS-S-005	66	ENTER A VALID DATE	Enter a valid date. Enter a two digit month, two digit day, and a four digit year.	N/A
PS-S-005	4429	ENTER ASSOCIATION NUMBER	Enter valid values according to error message specifications.	N/A
PS-S-005	4037	ENTER NEW PROVIDER NUMBER	Enter valid values according to error message specifications.	N/A
PS-S-005	8	ENTER PROVIDER NUMBER	Enter a valid Provider number. See the field definitions for formatting/ requirements for this field.	N/A
PS-S-005	4497	ENTER VALID PROVIDER NUMBER FOR PROCESSING	Enter valid values according to error message specifications.	N/A
PS-S-005	4620	ENTER VALID VALUE	Enter valid values according to error message specifications.	N/A
PS-S-005	4041	ENTER VALUE FOR CLIA NUMBER	Enter valid values according to error message specifications.	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-005	15	FUNCTION CHOSEN IS INVALID	Choose another function.	N/A
PS-S-005	65	FUNCTION KEY IS NOT CURRENTLY ACTIVE	The function selected cannot complete the task. Choose another Function.	N/A
PS-S-005	91	FUNCTION MODE IS INVALID; MUST BE ADD, CHANGE, OR INQUIRY	Choose the Add, Change, or Inquiry function.	N/A
PS-S-005	4014	GROUP ASSOCIATION ENTERED IS INVALID	N/A	Information message
PS-S-005	4623	GROUPASSOCIATION ROLE MUST BE BLANK FOR TAX GROUPS AND BILLING GROUPS	N/A	Information message
PS-S-005	4633	GROUP ID FOR '02' MUST HAVE HMO PROVIDER TYPE '067', '069', '087', OR '089	Enter a valid Group ID for the HMO Provider type.	N/A
PS-S-005	4634	GROUP ID FOR '04' MUST HAVE 1099 PROVIDER TYPE '088'	N/A	Information message
PS-S-005	4015	GROUP ID IS INVALID	N/A	Information message
PS-S-005	4426	GROUP ID NOT FOUND IN RELATION TABLE	N/A	Information message
PS-S-005	10017	GROUP PROVIDER MUST BE A GROUP BILLING OWNER FOR GROUP TYPE'01'	Enter valid values according to error message specification	N/A
PS-S-005	4071	GROUP PROVIDER NUMBER NOT FOUND	N/A	Information message
PS-S-005	4020	GROUP TYPE IS INVALID	N/A	Information message.
PS-S-005	8848	INVALID FUNCTION FOR THIS SELECTION	N/A	Information message.

Screen	Error	Description	Value You Key	Comments
PS-S-005	10023	LEGACY ID IS NOT ACCEPTED WHEN THE NPI IS AVAILABLE	Enter NPI instead of Legacy	N/A
PS-S-005	10056	LEGACY ID NOT ALLOWED FOR BILLING GROUPS.	N/A	Information message.
PS-S-005	10026	MULTIPLE GROUP BILLING OWNERS FOUND	Enter valid values according to error message specification	N/A
PS-S-005	9965	NEXT LOCATION IS DISPLAYED	N/A	Information message.
PS-S-005	17	NEXT PAGE DATA IS DISPLAYED	N/A	Information message
PS-S-005	8874	NPI NOT FOUND	N/A	Information message
PS-S-005	9964	PREVIOUS LOCATION IS DISPLAYED	N/A	Information message
PS-S-005	20	PREVIOUS PAGE DATA IS DISPLAYED	N/A	Information message
PS-S-005	4117	PROVIDER BASE ID NOT FOUND	N/A	Information message
PS-S-005	4682	PROVIDER BEING ADDED IS MANAGED CARE, GROUP ASSOCIATION MUST BE 1	N/A	Information message
PS-S-005	4683	PROVIDER BEING ADDED IS NOT IN MANAGED CARE, GROUP ASSOCIATION MUST BE 0	N/A	Information message
PS-S-005	4635	PROVIDER FEIN DOES NOT MATCH 1099 GROUP FEIN	N/A	Information message
PS-S-005	9924	PROVIDER ID IS NOT NUMERIC.	Enter a numeric Provider Id.	N/A
PS-S-005	8873	PROVIDER ID NOT FOUND	N/A	Information message

Screen	Error	Description	Value You Key	Comments
PS-S-005	10027	PROVIDER IS SANCTIONED. CANNOT BE ADDED TO A GROUP	Enter valid values according to error message specification	N/A
PS-S-005	16	PROVIDER NUMBER IS INVALID	Correct field value if keyed incorrectly. Otherwise, accept transaction with errors to generate TAD.	N/A
PS-S-005	4021	REASON CODE IS INVALID	Enter a valid Reason Code. See the field definitions for formatting and requirements for this field.	N/A
PS-S-005	4474	REASON CODE MUST BE CHANGED WHEN END DATE IS CHANGED	N/A	Information message
PS-S-005	4695	REASON CODE MUST BE GREATER THAN 000 IF END DATE IS BEFORE CURRENT DATE	N/A	Information message
PS-S-005	23	RECORD INSERTED	N/A	Information message
PS-S-005	25	RECORD UPDATED	N/A	Information message
PS-S-005	4120	RECORDS DISPLAYED	N/A	Information message
PS-S-005	4685	THIS PROVIDER TYPE CANNOT BE PART OF ANOTHER HMO GROUP	N/A	Information message
PS-S-005	29	TOP OF THE PAGE	N/A	Information message
PS-S-005	67	UNABLE TO RETURN TO PREVIOUS PROGRAM, CHOOSE THE EXIT BUTTON TO CONTINUE	Choose the EXIT button to continue processing.	

8.0 Entering Primary Billing Information

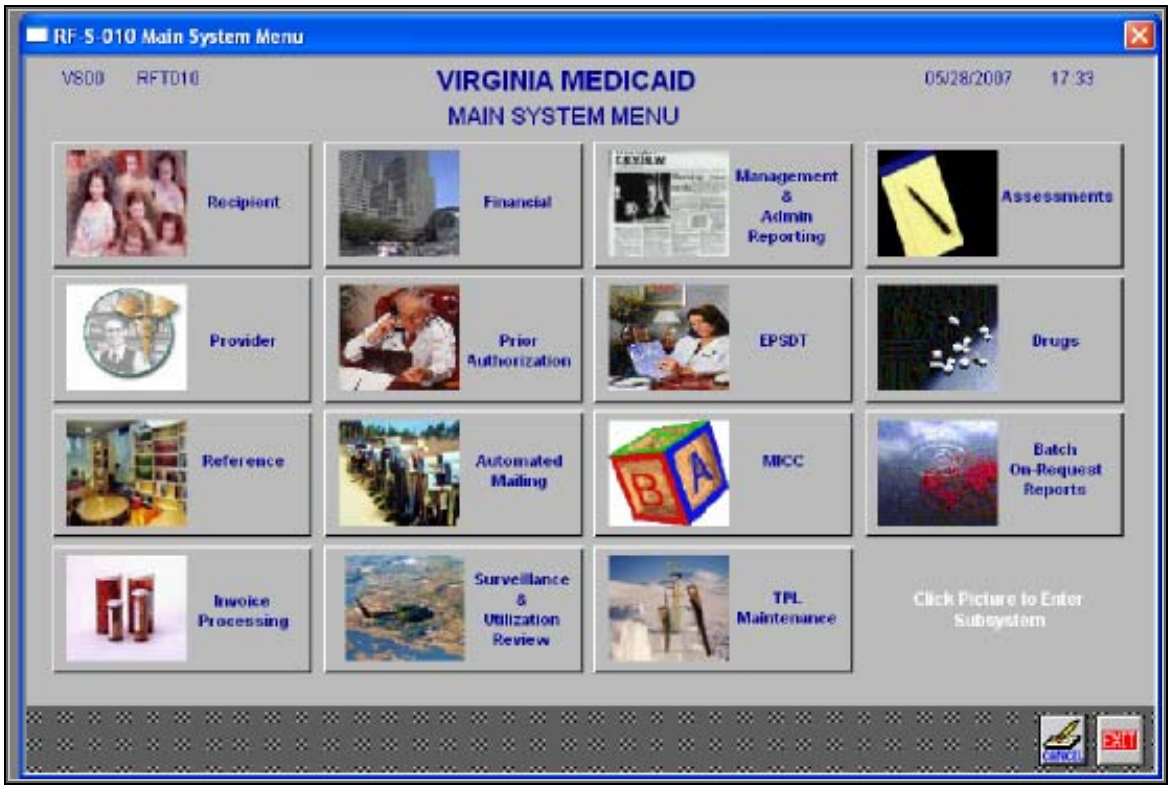
8.1 General Information

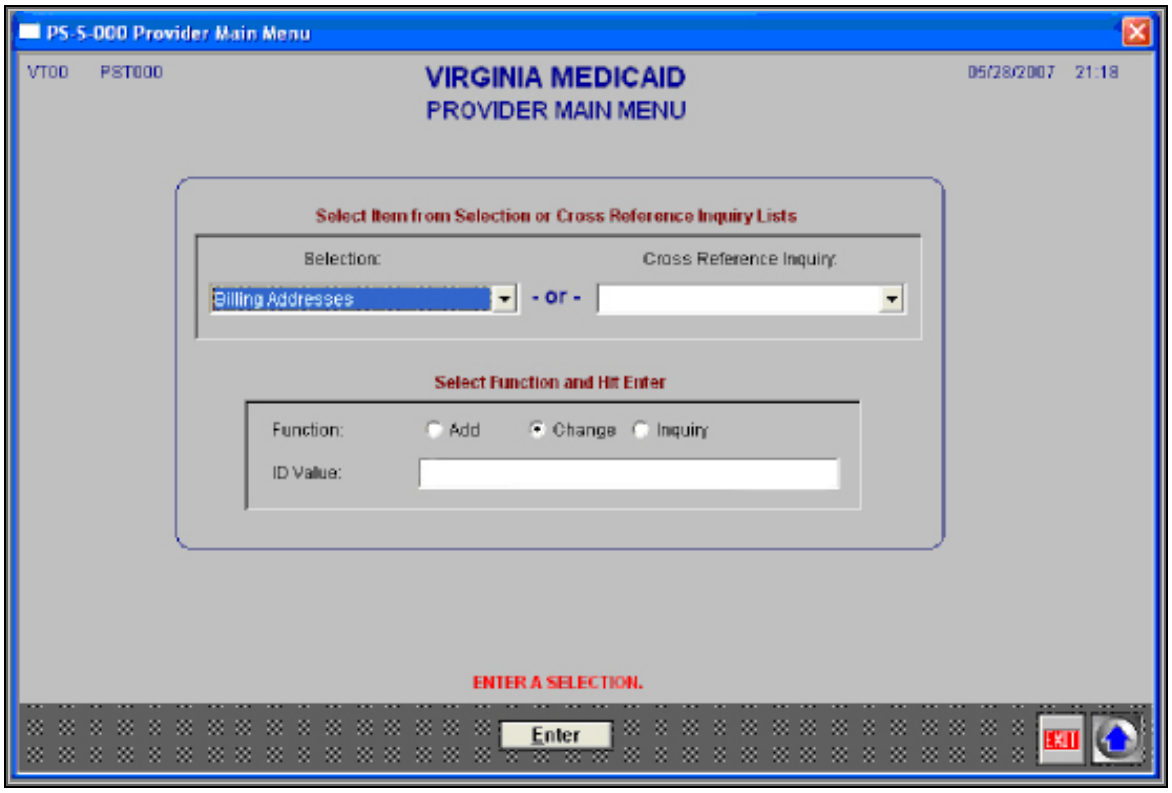
For providers who already have an NPI, but did not submit primary billing data prior to conversion, use the following procedures to enter primary billing data for an NPI.

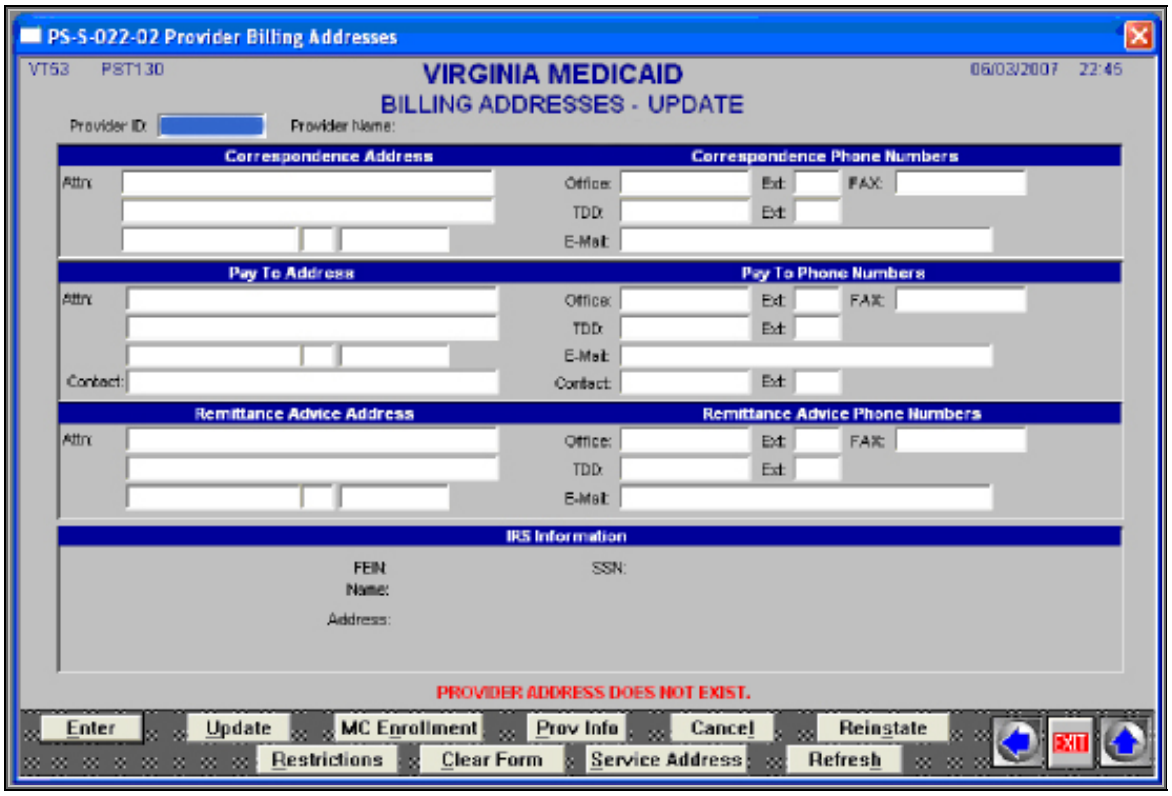
8.2 Screen Access

From the VaMMIS Main System Menu choose the Provider Sub-system:

1. On the Provider Main Menu Screen, select **Billing Addresses** from the **Selection** drop-down menu.
2. Select the **Add** or **Change** radio button in the **Function** field.
3. Enter the Provider Identification Number in the **ID Value** field. This must be a Legacy Provider Identification Number only.
4. Select **Enter**.




PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
05/28/2007 21:18
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cross Reference Inquiry:
Billing Addresses
- or -
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION.
Enter
EXIT

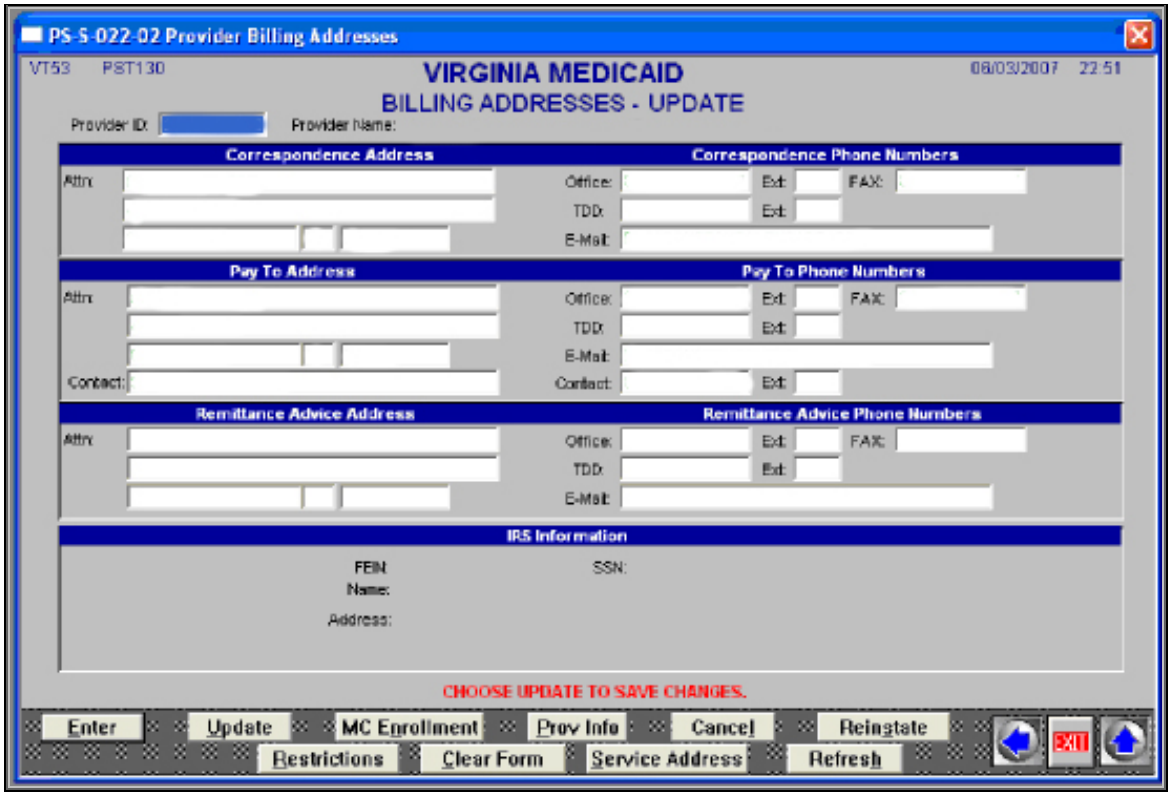

PS-S-022-02 Provider Billing Addresses
VT53 PST130
VIRGINIA MEDICAID
BILLING ADDRESSES - UPDATE
06/03/2007 22:45
Provider ID:
Provider Name:
Correspondence Address
Correspondence Phone Numbers
Pay To Address
Pay To Phone Numbers
Remittance Advice Address
Remittance Advice Phone Numbers
IRS Information
FEIN
SSN:
Name:
Address:
PROVIDER ADDRESS DOES NOT EXIST.
Enter
Update
MC Enrollment
Prov Info
Cancel
Reinstate
Restrictions
Clear Form
Service Address
Refresh
EXIT

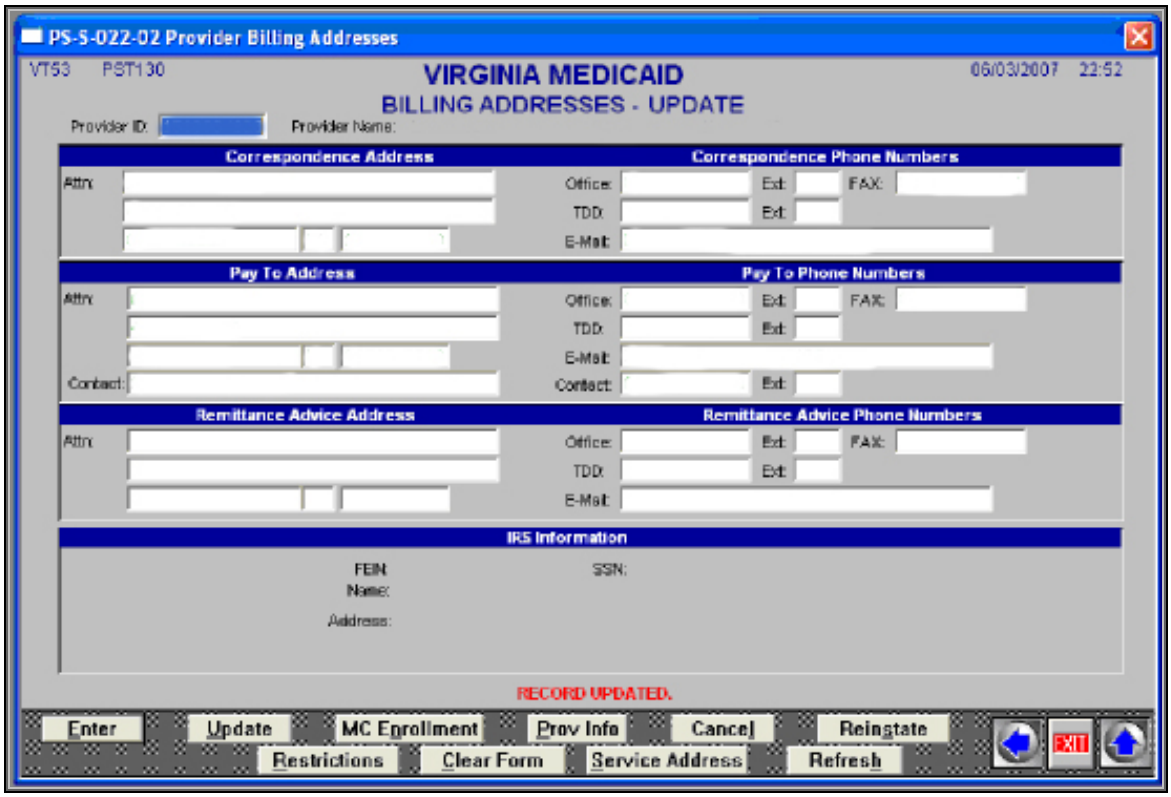
8.3 Entering Provider Data

1. After all data has been entered, click **Enter** to view edits.
2. Correct any errors
3. Click **Update**.

Screen	Data Element	Description	Value You Key	Comments
PS-S-022-02	Provider No	A unique identification number assigned to the servicing or billing provider. Can be a NPI/API or a Legacy	Enter a valid Provider ID Number.	N/A
PS-S-022-02	Provider Name	The name of the servicing or billing provider	N/A	System displayed
PS-S-022-02	Attn	The Attention Line in the address of the provider	Enter a valid Provider Address Additional Name.	N/A
PS-S-022-02	Provider Address Line	The delivery (street or delivery) address line of the servicing or billing provider.	Enter a valid Provider Address.	N/A
PS-S-022-02	City	The city delivery address line of the servicing or billing provider.	Enter a valid Provider City Delivery Address.	N/A
PS-S-022-02	State	The state delivery address line of the servicing or billing provider.	Enter a valid Provider State Delivery Address.	N/A
PS-S-022-02	Zip Code	The ZIP Code delivery address line of the servicing or billing provider.	Enter a valid Provider ZIP CODE.	N/A
PS-S-022-02	Contact	The individual person to contact at the servicing or billing location	Enter a valid Provider Contact Name.	N/A
PS-S-022-02	Office	The number indicating the phone number of the provider	Enter a valid Phone Number.	N/A

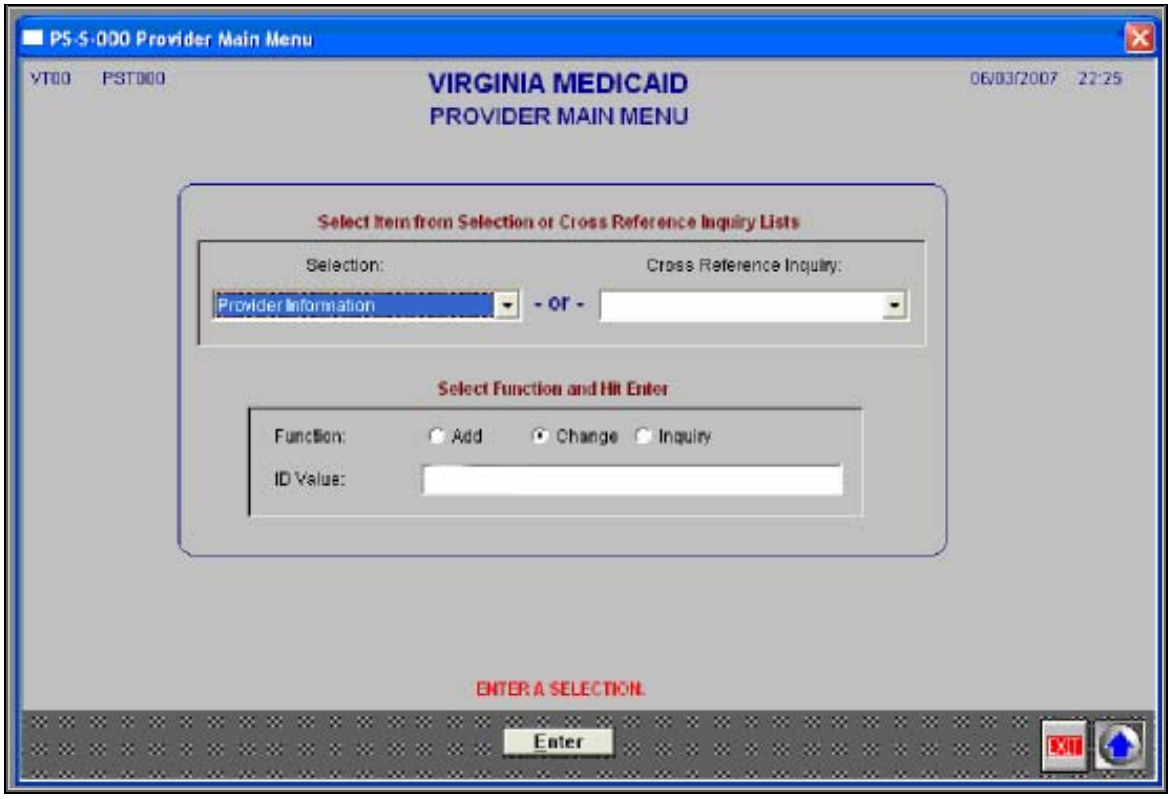
Screen	Data Element	Description	Value You Key	Comments
PS-S-022-02	Ext	The phone number extension for a provider	Enter a valid Provider Phone Extension Number.	When entered, must be numeric. Can be 1 to 4 positions
PS-S-022-02	Fax	The number indicating the fax phone number of the provider	Enter a valid Phone Number.	N/A
PS-S-022-02	TDD	The number indicating the TDD phone number of the provider	Enter a valid Phone Number.	N/A
PS-S-022-02	Ext	The TDD phone number extension for a provider.	Enter a valid Provider Phone Extension Number.	When entered, must be numeric. Can be 1 to 4 positions
PS-S-022-02	Date Updated	The date the Base ID maintenance transaction was processed in batch.	N/A	N/A
PS-S-022-02	E-mail	The E-mail address of the provider	Enter a valid Provider E-mail address.	N/A
PS-S-022-02	Contact (Phone Number)	The number indicating the phone number of the contact person for the provider	Enter a valid Phone Number.	N/A
PS-S-022-02	Ext	The Contact phone number extension for a provider.	Enter a valid Provider Phone Extension Number.	When entered, must be numeric. Can be 1 to 4 positions

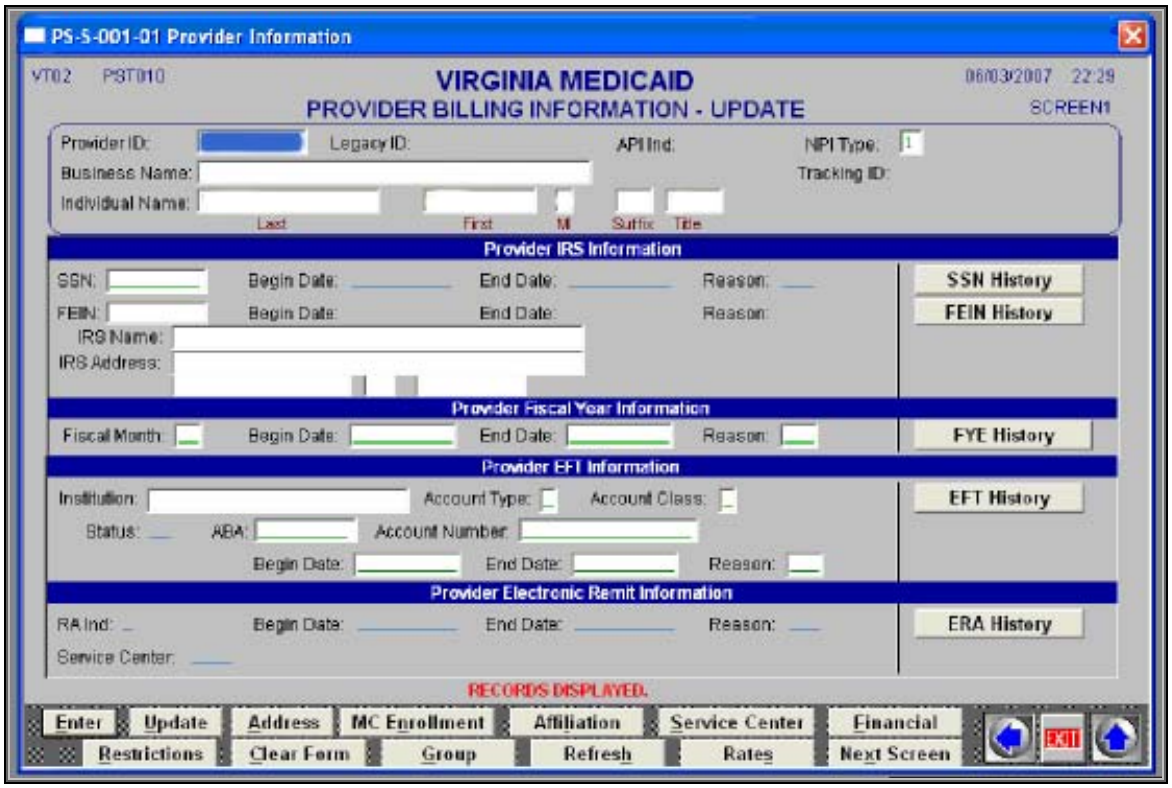

PS-S-022-02 Provider Billing Addresses
VT53 PST130
VIRGINIA MEDICAID
BILLING ADDRESSES - UPDATE
06/03/2007 22:51
Provider ID:
Provider Name:
Correspondence Address
Correspondence Phone Numbers
Attn:
Office:
Ext:
FAX:
TDD:
E-Mail:
Pay To Address
Pay To Phone Numbers
Contact:
Remittance Advice Address
Remittance Advice Phone Numbers
IRS Information
FEIN
SSN:
Name:
Address:
CHOOSE UPDATE TO SAVE CHANGES.
Enter
Update
MC Enrollment
Prov Info
Cancel
Reinstate
Restrictions
Clear Form
Service Address
Refresh
EXIT


PS-S-022-02 Provider Billing Addresses
VT53 PST130
VIRGINIA MEDICAID
BILLING ADDRESSES - UPDATE
06/03/2007 22:52
Provider ID:
Provider Name:
Correspondence Address
Correspondence Phone Numbers
Attn:
Office:
Ext:
FAX:
TDD:
E-Mail:
Pay To Address
Pay To Phone Numbers
Contact:
Remittance Advice Address
Remittance Advice Phone Numbers
IRS Information
FEIN
SSN:
Name:
Address:
RECORD UPDATED.
Enter
Update
MC Enrollment
Prov Info
Cancel
Reinstate
Restrictions
Clear Form
Service Address
Refresh
EXIT

From the VaMMIS Main System Menu click the Provider sub-system icon:

1. On the Provider Main Menu Screen, select **Provider Information** from the **Selection** drop-down menu.
2. Select the **Change** radio button in the **Function** field.
3. Enter the NPI in the **ID Value** field.
4. Select **Enter**.


PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
06/03/2007 22:25
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cross Reference Inquiry:
Provider Information
- or -
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION.
Enter
EXIT

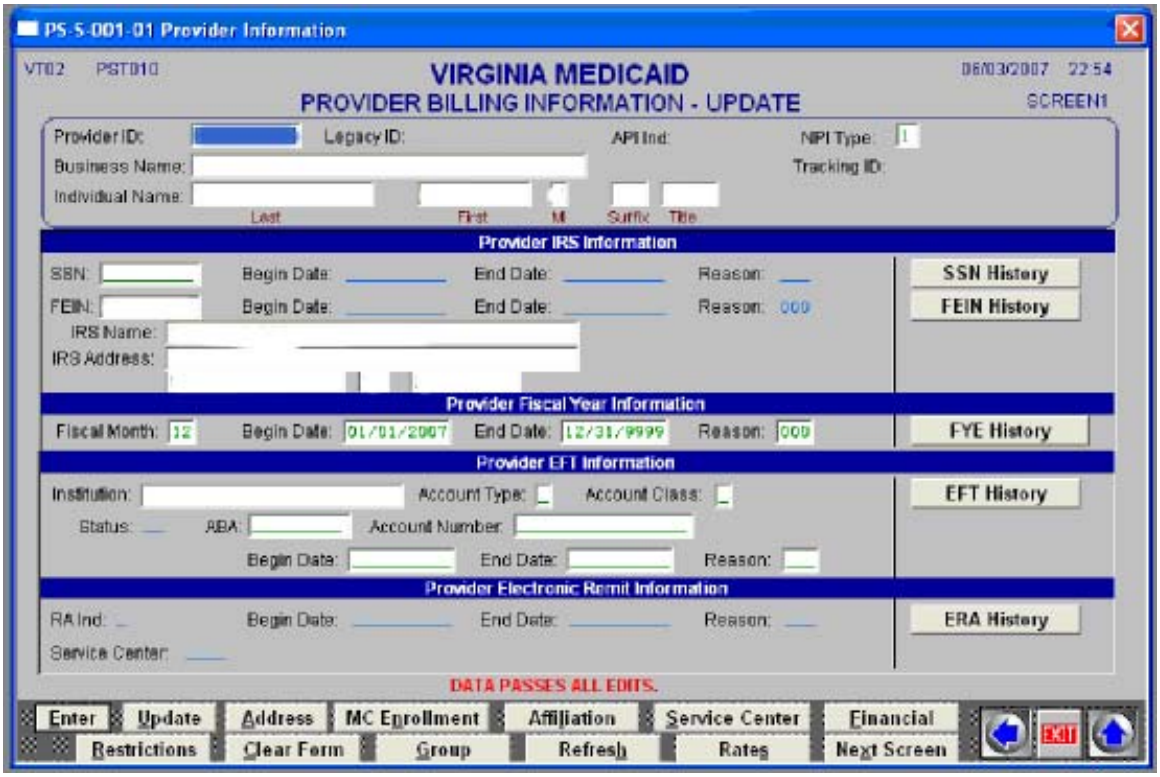

PS-S-001-01 Provider Information
VT02 PST010
VIRGINIA MEDICAID
PROVIDER BILLING INFORMATION - UPDATE
06/03/2007 22:29
SCREEN1
Provider ID:
Legacy ID:
API Ind:
NPI Type:
Business Name:
Tracking ID:
Individual Name:
Last
First
MI
Suffix
Title
Provider IRS Information
SSN:
Begin Date:
End Date:
Reason:
SSN History
FEIN:
FEIN History
IRS Name:
IRS Address:
Provider Fiscal Year Information
Fiscal Month:
FYE History
Provider EFT Information
Institution:
Account Type:
Account Class:
EFT History
Status:
ABA:
Account Number:
Provider Electronic Remit Information
RA Ind:
ERA History
Service Center:
RECORDS DISPLAYED.
Enter
Update
Address
MC Enrollment
Affiliation
Service Center
Financial
Restrictions
Clear Form
Group
Refresh
Rates
Next Screen
EXIT

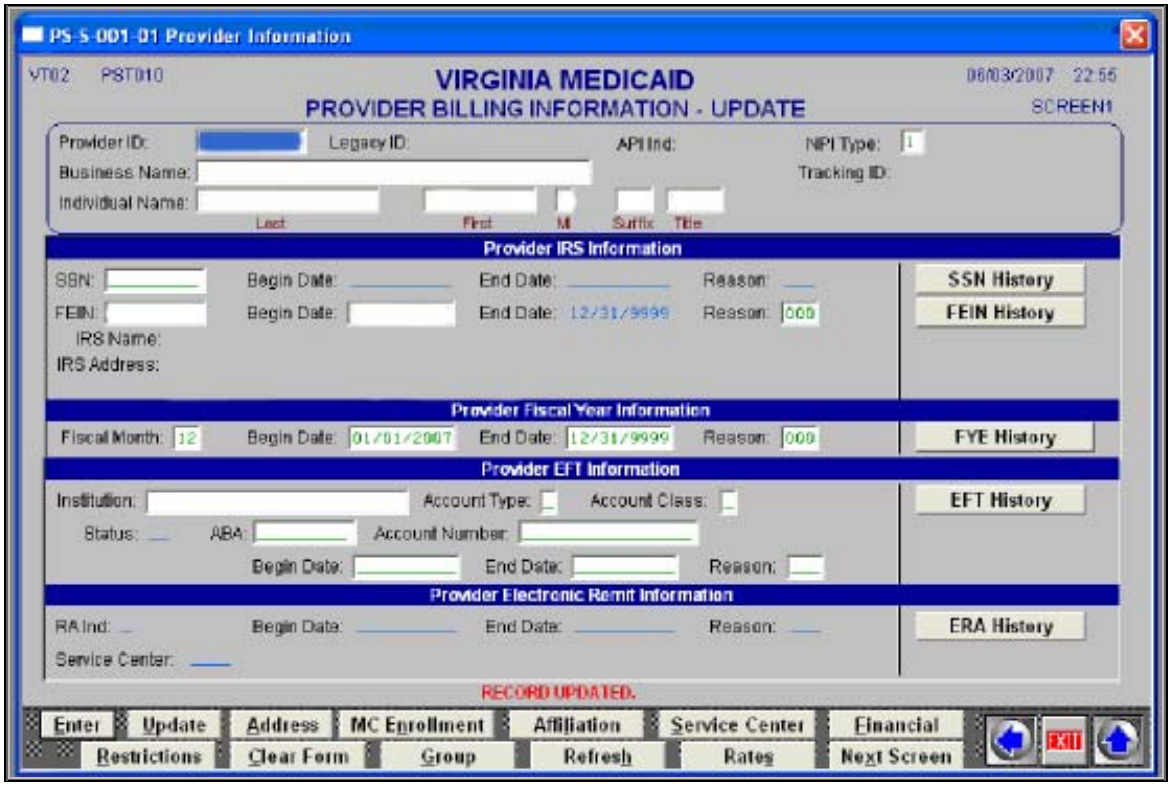
8.4 Entering Provider Data

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-01	SSN	The account number assigned to individuals by the Social Security Administration.	Enter a valid Provider Social Security Number.	Must be unique within NPI ID (DE#4700). Either the SSN or FEIN must be entered. Both may be entered, but at least one must be entered.
PS-S-001-01	FEIN	A number assigned to employers by the Internal Revenue Service also known as the Federal Employer Identification Number (FEIN) for tax recording purposes.	Enter a valid Provider FEIN Number.	Either SSN or FEIN is required. Both may be entered, but at least one must be entered FEIN must be unique within NPI for NPI TYPE = 02.
PS-S-001-01	IRS Name	The name of the Provider as listed with the Internal Revenue Service (IRS) as appears on the W-9 form.	Enter a valid Provider IRS Name.	This is required whenever FEIN is entered. It is 40 bytes free format.
PS-S-001-01	IRS Address	The address of the provider	Enter a valid address.	N/A
PS-S-001-01	IRS City	The city in the address for the provider	Enter a valid city.	N/A
PS-S-001-01	IRS State	The state in the address of the provider	Enter a valid State.	N/A
PS-S-001-01	IRS Zip	The ZIP code in the address of the provider	Enter a valid zip code.	N/A

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-01	Fiscal Month	The calendar month on which a provider's fiscal year ends	Enter a valid Provider Fiscal Year End Month.	The calendar month on which a provider's fiscal year ends; MM format. Required for specific provider types: 01, 02, 04, 06, 08, 10, 11, 12, 14, 15, 16, 17, 18, 19, 28, 29, 52, 53, 77, and 85.
PS-S-001-01	Begin Date	The date on which the Provider Fiscal Year End begins: MM/DD/CCYY format.	Enter a valid Provider Fiscal Year End Begin Date.	Required if there is an entry in the Provider Fiscal Year End field. Must be the first day of the month after the Fiscal Year Month. If a date not is entered, system will default to current date.
PS-S-001-01	End Date	The date on which the Provider Fiscal Year End ends; MM/DD/CCYY format	Enter a valid Provider Fiscal Year End Date.	Required if Fiscal Year End Month (DE 4057) is not zeros or spaces. Must be a valid date and can not be greater than the Fiscal Year Begin Date (DE 4229) Must be the last day of the month of the Fiscal Year Month. If a date is not entered, the system will default to 12/31/9999.

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-01	Reason	A code identifying the reason code for the Provider Fiscal Year End of a provider's eligibility status	Enter a valid Provider Reason Code for Provider Fiscal Year End.	Required if there is an entry in the Provider Fiscal Year End field. Must be a valid reason code for the Fiscal Year End. Refer to Appendix A (Reason Codes by Valid Values). Use the Online HELP system to find valid codes for this field.




PS-S-001-01 Provider Information
VT02 PST010
VIRGINIA MEDICAID
PROVIDER BILLING INFORMATION - UPDATE
06/03/2007 22:55
SCREEN1
Provider ID:
Legacy ID:
API Ind:
NPI Type:
Business Name:
Tracking ID:
Individual Name:
Last
First
MI
Suffix
Title
Provider IRS Information
SSN:
Begin Date:
End Date:
Reason:
SSN History
FEIN:
Begin Date:
End Date: 12/31/9999
Reason: 000
FEIN History
IRS Name:
IRS Address:
Provider Fiscal Year Information
Fiscal Month: 12
Begin Date: 01/01/2007
End Date: 12/31/9999
Reason: 000
FYE History
Provider EFT Information
Institution:
Account Type:
Account Class:
EFT History
Status:
ABA:
Account Number:
Begin Date:
End Date:
Reason:
Provider Electronic Remit Information
RA Ind:
Begin Date:
End Date:
Reason:
ERA History
Service Center:
RECORD UPDATED.
Enter
Update
Address
MC Enrollment
Affiliation
Service Center
Financial
Restrictions
Clear Form
Group
Refresh
Rates
Next Screen
EXIT

9.0 Entering an NPI for an Existing Provider

9.1 General Information

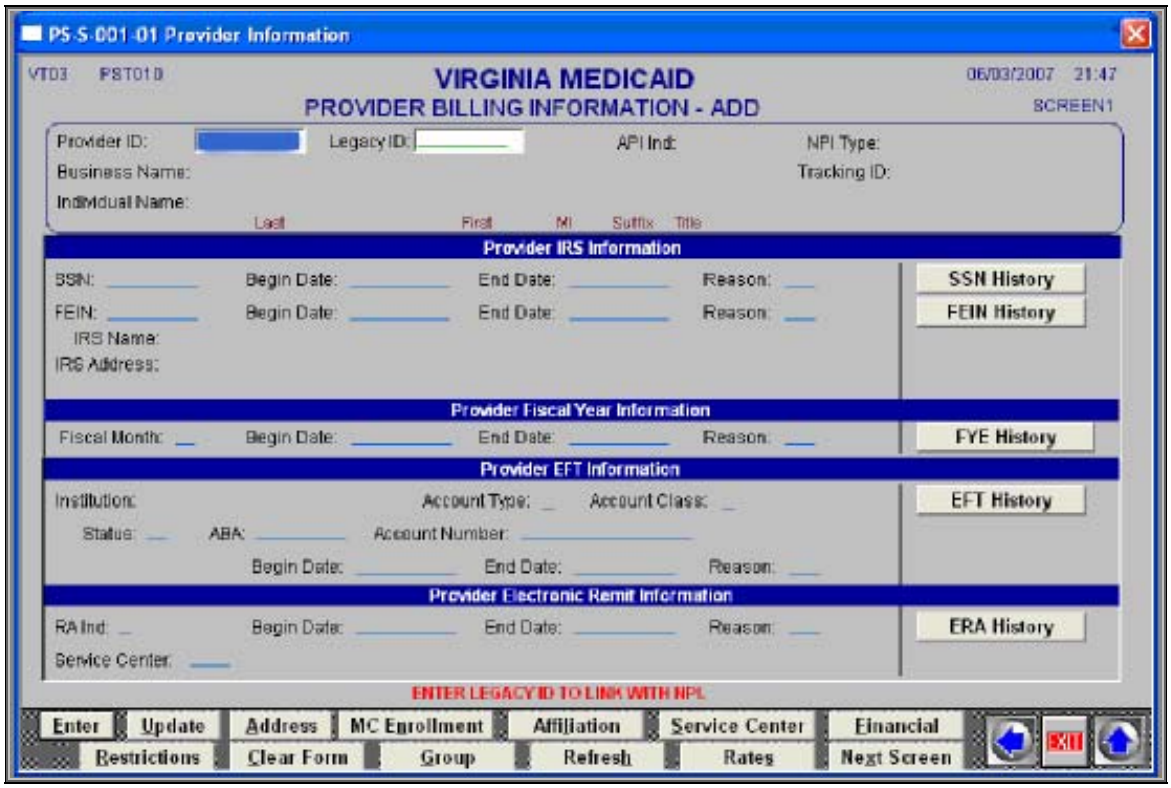
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services (HHS) adopt a standard unique health identifier for health care providers; therefore, all entities defined as "health care providers" must go through the enumeration process to receive an NPI and disseminate it to DMAS. Use the following procedures to link an existing provider to an NPI if it has not been reported previously.

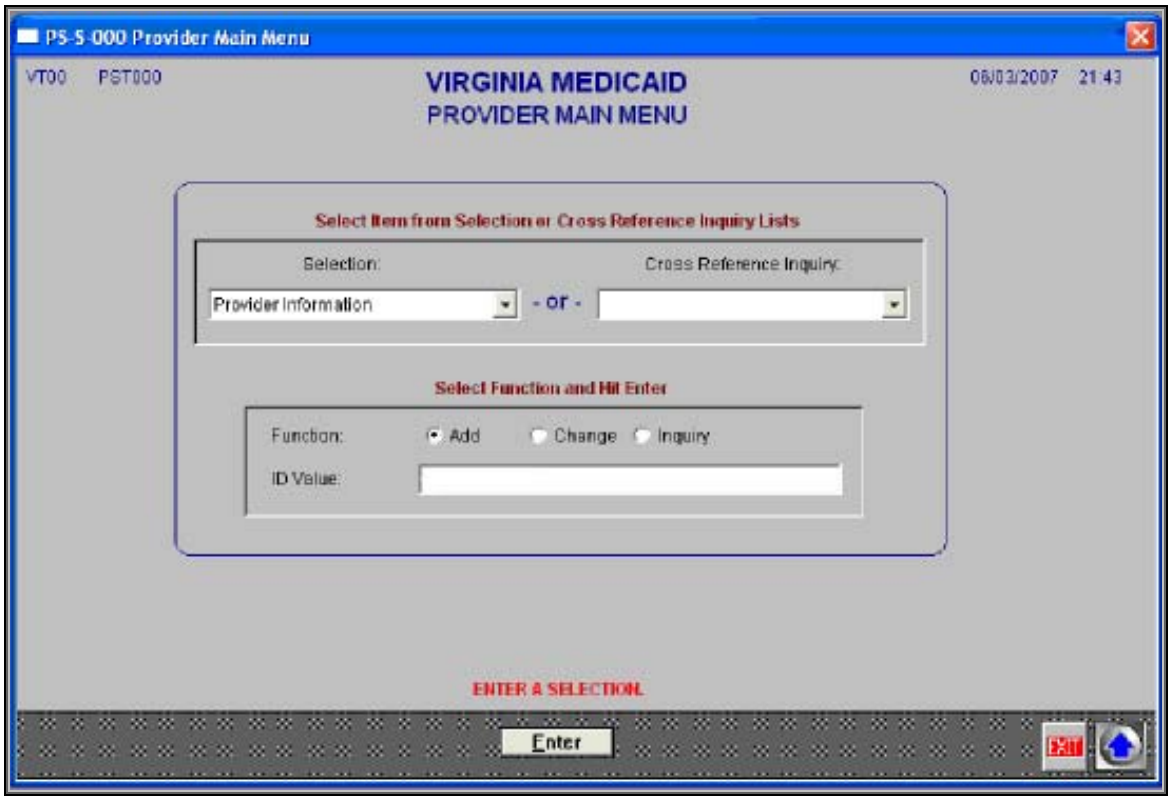
9.2 Screen Access

From the VaMMIS Main System Menu click the Provider sub-system icon.

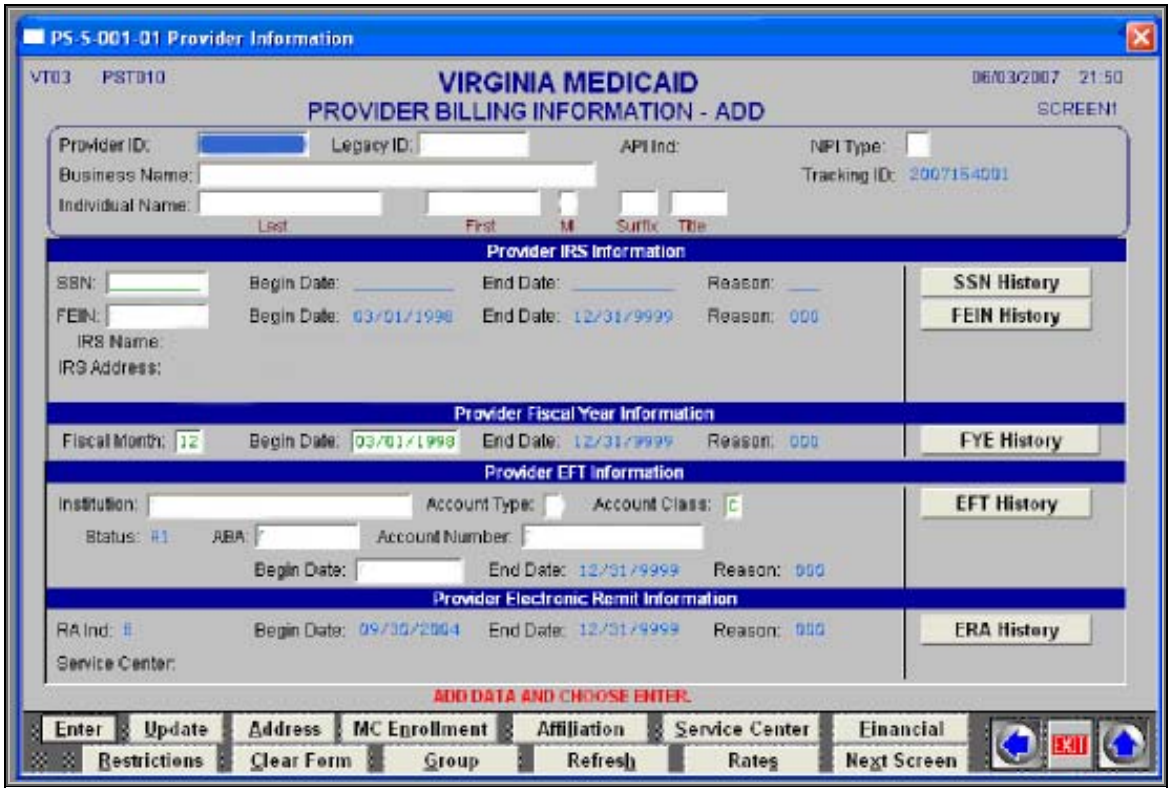
1. On the Provider Main Menu Screen, select **Provider Information** from the **Selection** drop-down menu.
2. Select the **Add** radio button in the **Function** field.
3. Enter the NPI in the **ID Value** field.
4. Select **Enter**.

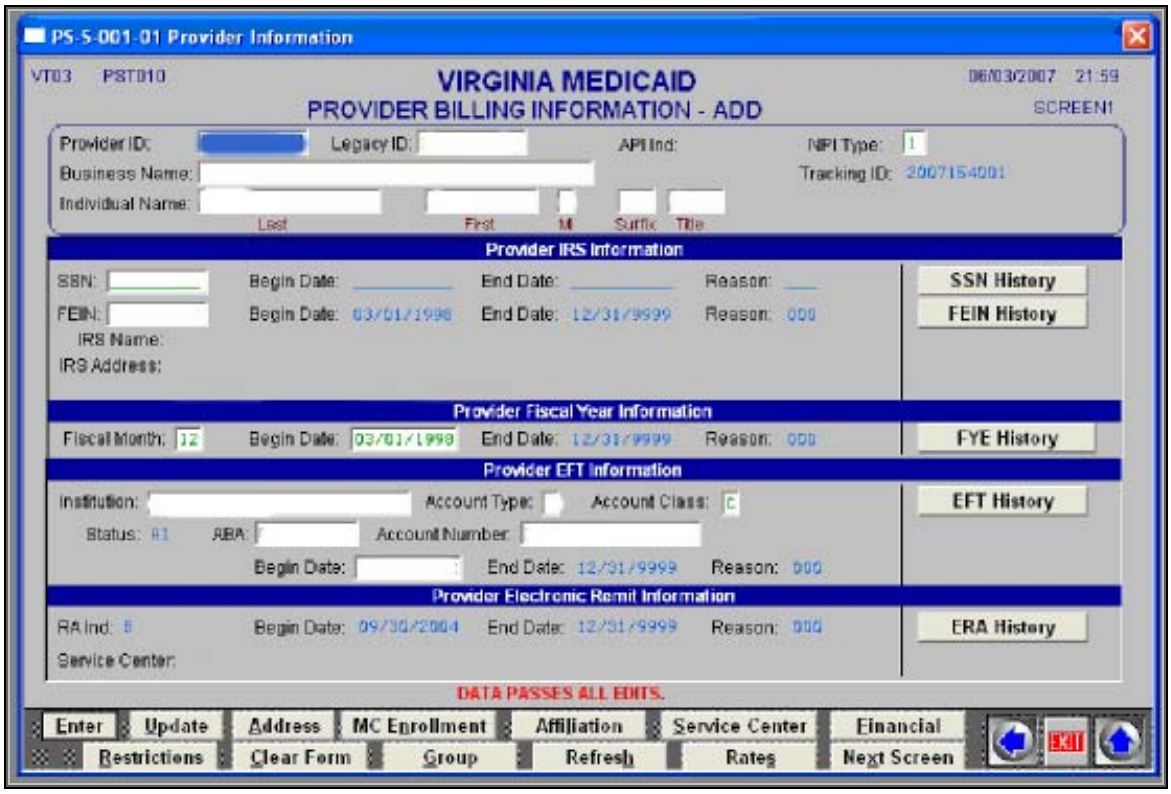
   Note: If the NPI already exists in VaMMIS, you will have to use NPI Legacy Maintenance screen (PS-S-019) to link another service location to an NPI.
5. Enter the legacy number in the **Legacy ID** field of Provider Information screen **PS-S-001-01**.
6. Select **Enter**.
7. Enter the NPI type in the **NPI Type** field of **Provider Information** screen **PS-S001-01**. NPI Type 1 indicates Individual and 2 indicates Organization.
8. Select **Enter**.
9. Select **Next Screen**.
10. Enter Correspondence Address data if it is not present, as it is required.
11. Pay To and Remittance Advice Address data is optional (as provided by the entity).
12. Select **Enter**.
13. Select **Update**.

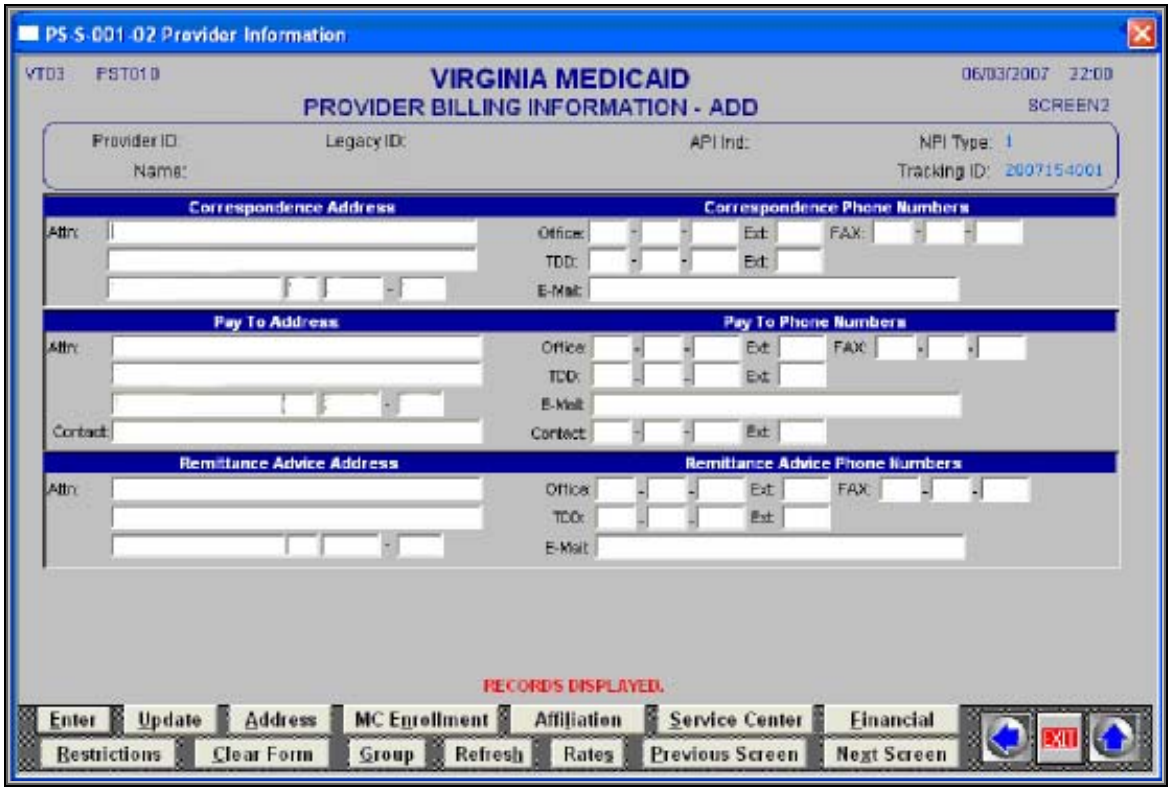

PS-S-001-01 Provider Information
VT03 PST01B
VIRGINIA MEDICAID
PROVIDER BILLING INFORMATION - ADD
06/03/2007 21:47
SCREEN1
Provider ID:
Legacy ID:
API Ind:
NPI Type:
Business Name:
Tracking ID:
Individual Name:
Last First MI Suffix Title
Provider IRS Information
SSN:
FEIN:
Begin Date:
End Date:
Reason:
IRS Name:
IRS Address:
SSN History
FEIN History
Provider Fiscal Year Information
Fiscal Month:
FYE History
Provider EFT Information
Institution:
Account Type:
Account Class:
Status:
ABA:
Account Number:
EFT History
Provider Electronic Remit Information
RA Ind:
Service Center:
ERA History
ENTER LEGACY ID TO LINK WITH NPI
Enter
Update
Address
MC Enrollment
Affiliation
Service Center
Financial
Restrictions
Clear Form
Group
Refresh
Rates
Next Screen
EXIT

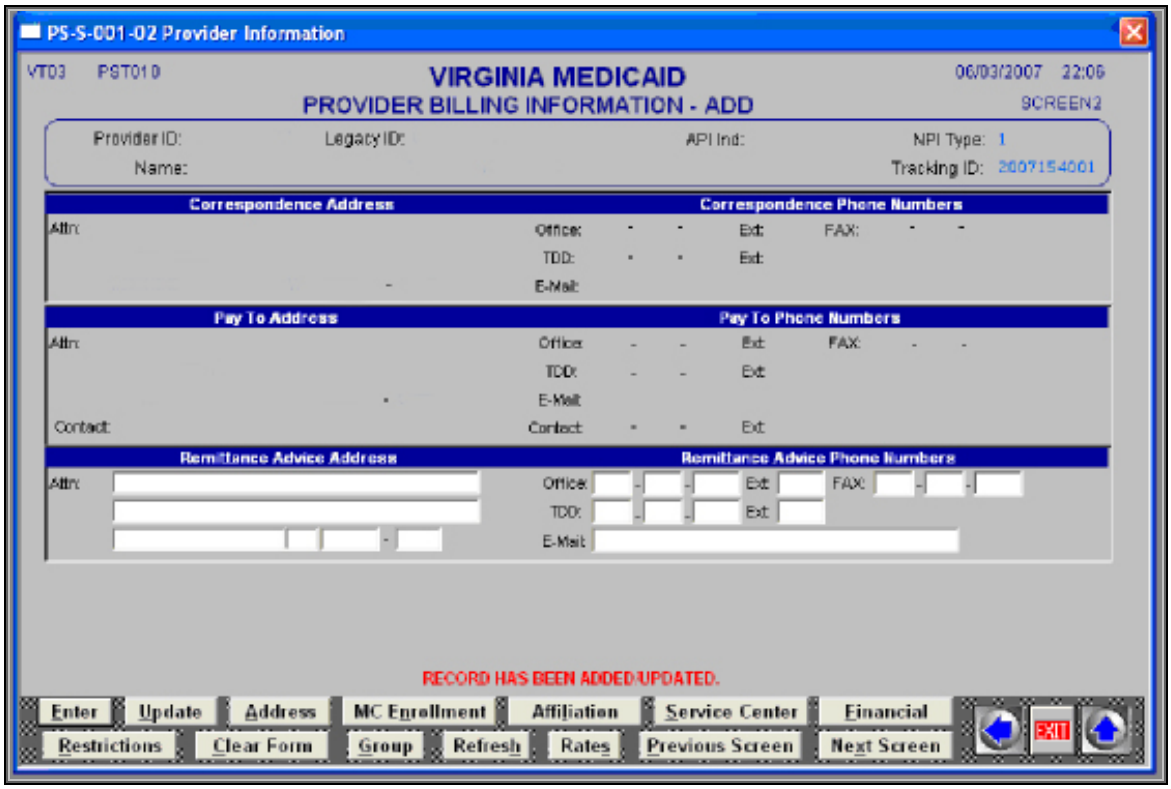

PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
06/03/2007 21:43
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cross Reference Inquiry:
Provider Information
- or -
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION
Enter
EXIT

RF-5-010 Main System Menu
VS00 RFT010
VIRGINIA MEDICAID
MAIN SYSTEM MENU
05/28/2007 17:33
Recipient
Financial
Management & Admin Reporting
Assessments
Provider
Prior Authorization
EPSDT
Drugs
Reference
Automated Mailing
MICC
Batch On-Request Reports
Invoice Processing
Surveillance & Utilization Review
TPL Maintenance
Click Picture to Enter Subsystem
CANCEL
EXIT


PS-5-001-01 Provider Information
VT03 PST010
VIRGINIA MEDICAID
PROVIDER BILLING INFORMATION - ADD
06/03/2007 21:50
SCREEN1
Provider ID:
Legacy ID:
API Ind:
NPI Type:
Business Name:
Tracking ID: 2007154001
Individual Name:
Last First M Suffix Title
Provider IRS Information
SSN:
Begin Date:
End Date:
Reason:
SSN History
FEIN:
Begin Date: 03/01/1998
End Date: 12/31/9999
Reason: 000
FEIN History
IRS Name:
IRS Address:
Provider Fiscal Year Information
Fiscal Month: 12
Begin Date: 03/01/1998
End Date: 12/31/9999
Reason: 000
FYE History
Provider EFT Information
Institution:
Account Type:
Account Class: C
EFT History
Status: 81
ABA:
Account Number:
Begin Date:
End Date: 12/31/9999
Reason: 000
Provider Electronic Remit Information
RA Ind: 8
Begin Date: 09/30/2004
End Date: 12/31/9999
Reason: 000
ERA History
Service Center:
ADD DATA AND CHOOSE ENTER.
Enter
Update
Address
MC Enrollment
Affiliation
Service Center
Financial
Restrictions
Clear Form
Group
Refresh
Rates
Next Screen
EXIT


PS-S-001-01 Provider Information
VT03 PST010
VIRGINIA MEDICAID
PROVIDER BILLING INFORMATION - ADD
06/03/2007 21:59
SCREEN1
Provider ID:
Legacy ID:
API Ind:
NPI Type: 1
Business Name:
Tracking ID: 2007154001
Individual Name:
Last
First
MI
Suffix
Title
Provider IRS Information
SSN:
Begin Date:
End Date:
Reason:
SSN History
FEIN:
Begin Date: 03/01/1998
End Date: 12/31/9999
Reason: 000
FEIN History
IRS Name:
IRS Address:
Provider Fiscal Year Information
Fiscal Month: 12
Begin Date: 03/01/1998
End Date: 12/31/9999
Reason: 000
FYE History
Provider EFT Information
Institution:
Account Type:
Account Class: C
EFT History
Status: 01
ABA:
Account Number:
Begin Date:
End Date: 12/31/9999
Reason: 000
Provider Electronic Remit Information
RA Ind: 0
Begin Date: 09/30/2004
End Date: 12/31/9999
Reason: 000
ERA History
Service Center:
DATA PASSES ALL EDITS.
Enter
Update
Address
MC Enrollment
Affiliation
Service Center
Financial
Restrictions
Clear Form
Group
Refresh
Rates
Next Screen
EXIT


PS-S-001-02 Provider Information
VT03 PST010
VIRGINIA MEDICAID
PROVIDER BILLING INFORMATION - ADD
06/03/2007 22:00
SCREEN2
Provider ID:
Legacy ID:
API Ind:
NPI Type: 1
Name:
Tracking ID: 2007154001
Correspondence Address
Correspondence Phone Numbers
Attn:
Office:
Ext:
FAX:
TDD:
E-Mail:
Pay To Address
Pay To Phone Numbers
Contact:
Remittance Advice Address
Remittance Advice Phone Numbers
RECORDS DISPLAYED.
Enter
Update
Address
MC Enrollment
Affiliation
Service Center
Financial
Restrictions
Clear Form
Group
Refresh
Rates
Previous Screen
Next Screen
EXIT


PS-S-001-02 Provider Information
VT03 PST010
VIRGINIA MEDICAID
PROVIDER BILLING INFORMATION - ADD
06/03/2007 22:06
SCREEN2
Provider ID:
Legacy ID:
API Ind:
NPI Type: 1
Name:
Tracking ID: 2007154001
Correspondence Address
Correspondence Phone Numbers
Attn:
Office:
Ext:
FAX:
TDD:
Ext:
E-Mail:
Pay To Address
Pay To Phone Numbers
Attn:
Office:
Ext:
FAX:
TDD:
E-Mail:
Contact:
Contact:
Ext:
Remittance Advice Address
Remittance Advice Phone Numbers
Attn:
Office:
Ext:
FAX:
TDD:
Ext:
E-Mail:
RECORD HAS BEEN ADDED/UPDATED.
Enter
Update
Address
MC Enrollment
Affiliation
Service Center
Financial
Restrictions
Clear Form
Group
Refresh
Rates
Previous Screen
Next Screen
EXIT

10.0 Canceling Provider Eligibility Screen

10.1 General Information

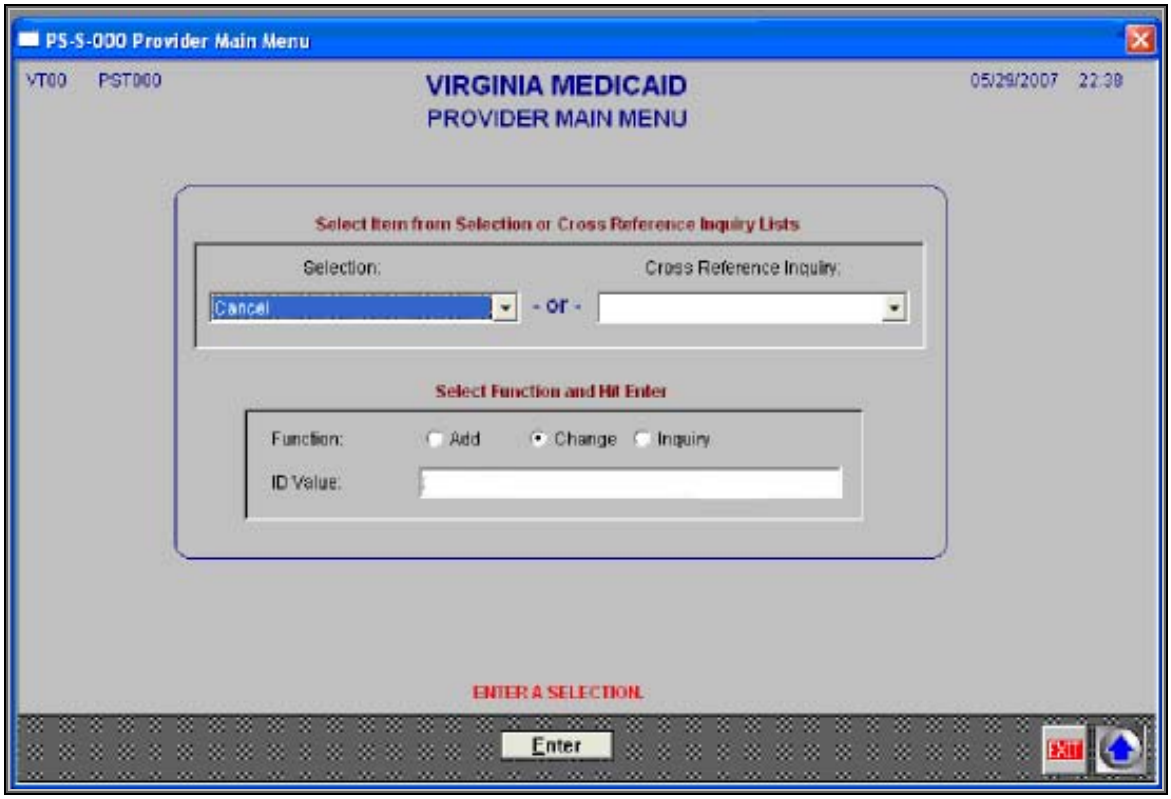
This screen allows the immediate online cancellation of an active provider. The cancel date may be the current or future date. A cancel letter will be generated when the Provider is canceled informing the provider of the cancellation in the specific and/or all Medicaid programs with a reason and the date of the cancellation. To cancel the program(s) of a provider, type over the End Date of the record(s), type over the Reason Code and choose Enter. If no errors occur, choose Update at the bottom of the screen to post the entry to the database.

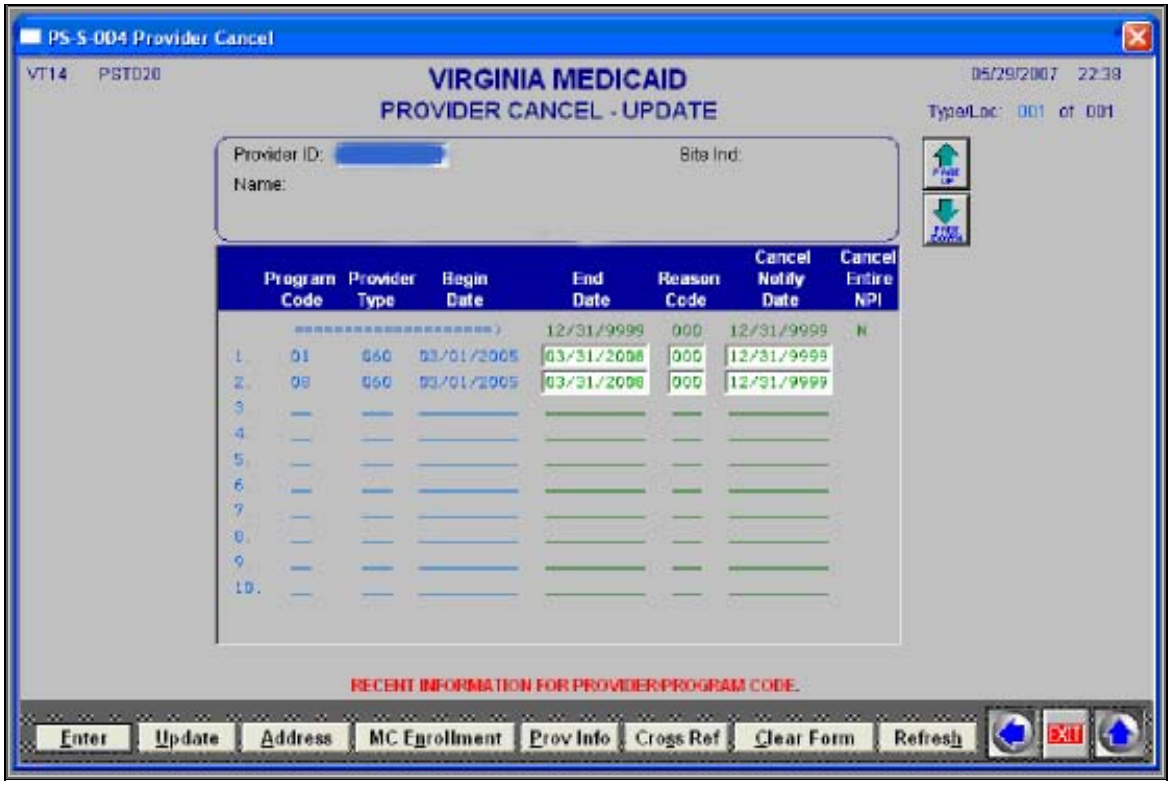
10.2 Screen Access

From the VaMMIS Main System Menu choose the Provider Sub-system:

1. On the Provider Main Menu Screen, select **Cancel** from the **Selection** drop-down menu.
2. Select the **Change** radio button in the **Function** field.
3. Enter the Provider Identification Number in the **ID Value** field.
4. Select **Enter**.

RF-S-010 Main System Menu
VS00 RFT010
VIRGINIA MEDICAID
MAIN SYSTEM MENU
05/28/2007 17:33
Recipient
Financial
Management & Admin Reporting
Assessments
Provider
Prior Authorization
EPSDT
Drugs
Reference
Automated Mailing
MICC
Batch On-Request Reports
Invoice Processing
Surveillance & Utilization Review
TPL Maintenance
Click Picture to Enter Subsystem
Cancel
Exit


PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
05/29/2007 22:39
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cancel
- or -
Cross Reference Inquiry:
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION
Enter
Exit


PS-S-004 Provider Cancel
VT14 PST020
VIRGINIA MEDICAID
PROVIDER CANCEL - UPDATE
05/29/2007 22:38
Type/Loc: 001 of 001
Provider ID:
Name:
Bita Ind:
Program Code
Provider Type
Begin Date
End Date
Reason Code
Cancel Notify Date
Cancel Entire NPI
12/31/9999 000 12/31/9999 N
1. 01 060 03/01/2005 03/31/2008 000 12/31/9999
2. 08 060 03/01/2005 03/31/2008 000 12/31/9999
RECENT INFORMATION FOR PROVIDER/PROGRAM CODE.
Enter
Update
Address
MC Enrollment
Prov Info
Cross Ref
Clear Form
Refresh
EXIT

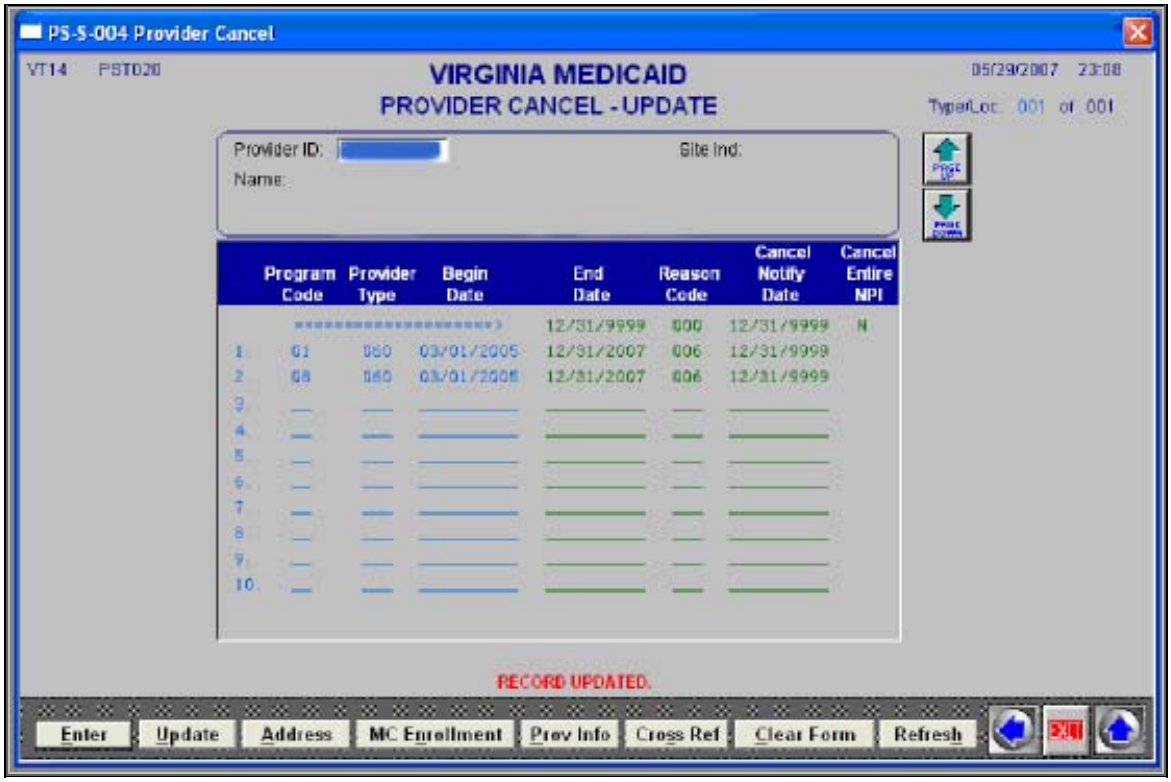
10.3 Entering Provider Data

1. After all data has been entered, click **Enter** to view edits.
2. Correct any errors.
3. Click **Update**.

Screen	Data Element	Description	Value You Key	Comments
PS-S-004	Provider ID	A unique identification number assigned to the servicing or billing provider. Can be a NPI/API or a Legacy	Enter a valid Provider ID Number.	N/A
PS-S-004	Provider Name	The name of the servicing or billing provider	N/A	System displayed
PS-S-004	Program Code	A code identifying the Program of a Provider under the State Plan. Use the Online HELP system to find valid codes for this field.	N/A	System displayed If Program 01 (Medicaid) is cancelled, all other all programs except 08 (TDO – Temporary Detention Order) will be cancelled as well.
PS-S-004	Provider Type	A code that designates the classification of a provider under the State plan	N/A	System displayed
PS-S-004	Begin Date	The date on which the Provider Program Code begins: MM/DD/CCYY format.	N/A	System displayed

Screen	Data Element	Description	Value You Key	Comments
PS-S-004	End Date	The date on which the Provider Program Code ends; MM/DD/CCYY format	Enter a valid date.	Must be a valid date, cannot be less than Provider Program Code Begin Date, and must be at least 30 day after the Provider Cancellation Notification Date.
PS-S-004	Reason Code	A code identifying the Provider Cancel Reason Code of the provider's eligibility	Enter a valid Provider Cancel Reason Code.	Use the Online HELP system to find valid codes for this field.
PS-S-004	Cancel Notify Date	When a Cancel Reason Code is entered for a Provider, a Cancel Letter will be sent to the Provider that day stating that the Provider will be cancelled effective as of the Cancel Begin Date entered on the Cancel Screen.	Enter a valid Cancel Notification Begin Date.	This field is optional. If entered, must be a valid date. The user may enter the date that he cancelled the Provider. Must be greater than the Provider Program Code Begin Date. Can be up to one (1) month greater than the Provider Cancel End Date. If a date not is entered, system will default to current date.
PS-S-004	Cancel Entire NPI	Must be a "Y" or "N". "Y" means cancel all programs for every Provider Number who has the NPI number entered. "N" means no action will occur.	Must be a "Y" or "N". "Y" means cancel all programs for every Provider Number who has the NPI number entered. "N" means no action will occur.	This field can only be used when a NPI number is entered into the PROV ID field.

Screen	Data Element	Description	Value You Key	Comments
PS-S-004	Site Ind.	This field contains a consecutive number for each unique location an NPI or API provider is using for a servicing address. An NPI or API may have multiple provider types that share the same servicing address. They also may have multiple servicing addresses.	N/A	System displayed
PS-S-004	Provider Address Line	The address of the provider	N/A	System displayed
PS-S-004	Provider Address City	The city in the address for the provider	N/A	System displayed
PS-S-004	Provider Address State	The state in the address of the provider	N/A	System displayed
PS-S-004	Provider Address Zip Code	The ZIP code in the address of the provider	N/A	System displayed
PS-S-004	Type/Location Number	Total Type/Location number of the provider	N/A	System displayed



10.4 Error Messages

Screen	Error	Description	Value You Key	Comments
PS-S-004	42	ACCESS TO THE PROGRAM IS NOT AUTHORIZED	N/A	User does not have access to the screens chosen.
PS-S-004	4408	ACTIVE PROVIDER; REINSTATE NOT ALLOWED	N/A	Information message
PS-S-004	4654	ALL PROGRAMS EXCEPT 08 FOR THE BASE WILL BE CLOSED CHOOSE UPDATE	N/A	Information message
PS-S-004	4653	ALL PROGRAMS EXCEPT 08 WILL BE CLOSED CHOOSE UPDATE.	N/A	Information message
PS-S-004	4159	BASE ID NOT FOUND FOR EXISTING PROVIDER	N/A	Information message

Screen	Error	Description	Value You Key	Comments
PS-S-004	13	BEGIN DATE IS INVALID	Enter a valid Begin date. See the Online HELP system for valid formatting/date range.	N/A
PS-S-004	4397	BEGIN DATE MUST BE GREATER THAN PREVIOUS END DATE	Enter a Begin date falling after the Previous End date.	N/A
	4425	BEGIN DATE MUST BE LESS THAN THE CURRENT DATE	Enter a valid Begin date.	N/A
	4400	CANCEL DATE IS INVALID	Enter a valid Cancel date.	N/A
	4403	CANCEL DATE MUST BE GREATER THAN BEGIN DATE	Enter a Cancel date falling after Current date.	N/A
	4395	CANCEL ENTIRE NPI MUST BE "Y" OR "N"	Change the data specified.	N/A
PS-S-004	4617	CANCEL REASON CODE '009' IS FOR AUTOMATIC CANCEL ONLY	N/A	Information message
PS-S-004	4655	CANCELING MEDICAID PROGRAM UNABLE TO CANCEL OTHER PROGRAMS	N/A	Information message
PS-S-004	39	CHOOSE UPDATE TO SAVE CHANGES	Choose the update button to save the changes.	N/A
PS-S-004	2	DATA NOT CHANGED	N/A	Information message
PS-S-004	68	DATA REFRESHED	N/A	Information message
PS-S-004	4527	DATE CONFLICT WITH APPLY TO BASE PROVIDER RECORD UPDATED.	N/A	Information message
PS-S-004	14	END DATE IS INVALID	Choose another function. See the Online HELP system for valid formatting/date range.	N/A
PS-S-004	4401	END DATE MUST BE AT LEAST 30 DAYS AFTER CANCEL DATE	Enter a valid End date.	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-004	5	END DATE MUST BE GREATER THAN BEGIN DATE	Enter an End Date that falls after the begin date. See the field definitions for valid end/begin date specifications.	N/A
PS-S-004	4081	ENTER NUMERIC PROVIDER NUMBER	Enter valid values according to error message specifications.	N/A
PS-S-004	4406	ERROR WHEN READING THE FILE	N/A	Information message
PS-S-004	4407	ERROR WHEN UPDATING THE FILE	N/A	Information message
PS-S-004	4669	ERROR WHILE CALLING CPD200 PROGRAM	N/A	Information message
PS-S-004	4668	ERROR WHILE WRITING TO CPF015 FILE	N/A	Information message
PS-S-004	4552	ESTABLISH TAX GROUP RELATIONSHIP BEFORE REINSTATING THE PROVIDER	N/A	Information message
PS-S-004	5022	FIRST RECORD IS ALREADY BEING DISPLAYED	N/A	Information message
PS-S-004	4396	FORM INDICATOR MUST BE '0', '1', '2', '3', OR '4'	N/A	Information message
PS-S-004	15	FUNCTION CHOSEN IS INVALID	N/A	Information message
PS-S-004	5023	LAST RECORD IS ALREADY BEING DISPLAYED	N/A	Information message
PS-S-004	4476	PROVIDER CANCELLED; CANCEL NOT ALLOWED	N/A	Information message
PS-S-004	22	PROVIDER NAME NOT FOUND	N/A	Information message

Screen	Error	Description	Value You Key	Comments
PS-S-004	16	PROVIDER NUMBER IS INVALID	Correct field value if keyed incorrectly. Otherwise, accept transaction with errors to generate TAD.	
PS-S-004	4258	PROVIDER PROGRAM END DATE MUST BE GREATER THAN BEGIN DATE	N/A	Information message
PS-S-004	4663	PROVIDER PROGRAM END DATE SHOULD BE CHANGED WHEN REASON CODE CHANGED	N/A	Information message
PS-S-004	4399	REASON CODE CANNOT BE '000' FOR CANCEL	N/A	Information message
PS-S-004	4398	REASON CODE CANNOT BE '000' FOR PAST END DATE	N/A	Information message
PS-S-004	4021	REASON CODE IS INVALID	Enter a valid Reason Code. See the field definitions for formatting and requirements for this field.	N/A
PS-S-004	4008	RECENT INFORMATION FOR PROVIDER/PROGRAM CODE	N/A	Information message
PS-S-004	4404	RECORD ALREADY CANCELLED	N/A	Information message
PS-S-004	24	RECORD FOR UPDATE NOT FOUND	N/A	Information message
PS-S-004	25	RECORD UPDATED	N/A	Information message

11.0 Application Tracking Procedures Screen

11.1 General Information

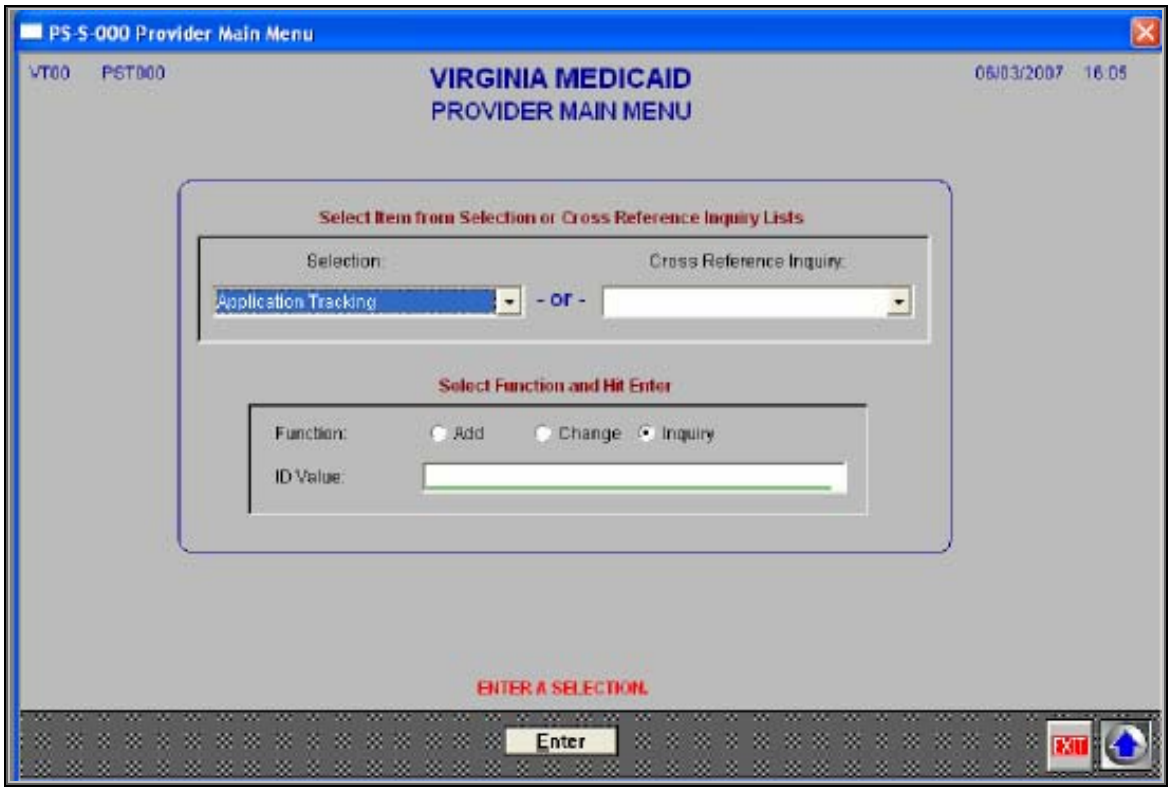
The Application Tracking Menu screen is used to access the Application Tracking Inquiry screen (PS-S-072), the Application Tracking Add/Update screen (PS-S073), and the Application Tracking Approval screen (PS-S-074). The Application Tracking Inquiry screen (PS-S-072) can only be accessed in Inquiry mode and does not require a partial 7-byte or full Tracking ID to gain access. The Application Tracking Add/Update screen (PS-S-073) can be accessed in add, change, or inquiry mode. It does require a full Tracking ID to gain access in inquiry or change mode. No tracking ID can be entered when in add mode when gaining access to the Application Tracking Add/Update screen (PS-S-073). The Application Tracking Approval screen (PS-S-074) can only be accessed in change or inquiry mode, and does require a partial 7-byte or full Tracking ID to gain access.

11.2 Screen Access

From the VaMMIS Main System Menu choose the Provider Sub-system:

1. On the **Provider Main Menu** screen, select **Application Tracking** from the **Selection** drop-down menu**.**
2. Select the **Inquiry** radio button in the **Function** field.
3. Select **Enter**.

RF-S-010 Main System Menu
VS00 RFT010
VIRGINIA MEDICAID
MAIN SYSTEM MENU
05/28/2007 17:33
Recipient
Financial
Management & Admin Reporting
Assessments
Provider
Prior Authorization
EPSDT
Drugs
Reference
Automated Mailing
MICC
Batch On-Request Reports
Invoice Processing
Surveillance & Utilization Review
TPL Maintenance
Click Picture to Enter Subsystem
CANCEL
EXIT


PS-S-000 Provider Main Menu
VT00 PST000
VIRGINIA MEDICAID
PROVIDER MAIN MENU
06/03/2007 16:05
Select Item from Selection or Cross Reference Inquiry Lists
Selection:
Cross Reference Inquiry:
Application Tracking
- or -
Select Function and Hit Enter
Function:
Add
Change
Inquiry
ID Value:
ENTER A SELECTION
Enter
EXIT

PS-S-071 Application Tracking Menu
VTA1 PSTD71
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING
MENU
08/03/2007 16:05
Select Item from Selection
Selection:
Select Function and Hit Enter
Function: Add Change Inquiry
Tracking ID:
ENTER SELECTION.
Enter
EXIT

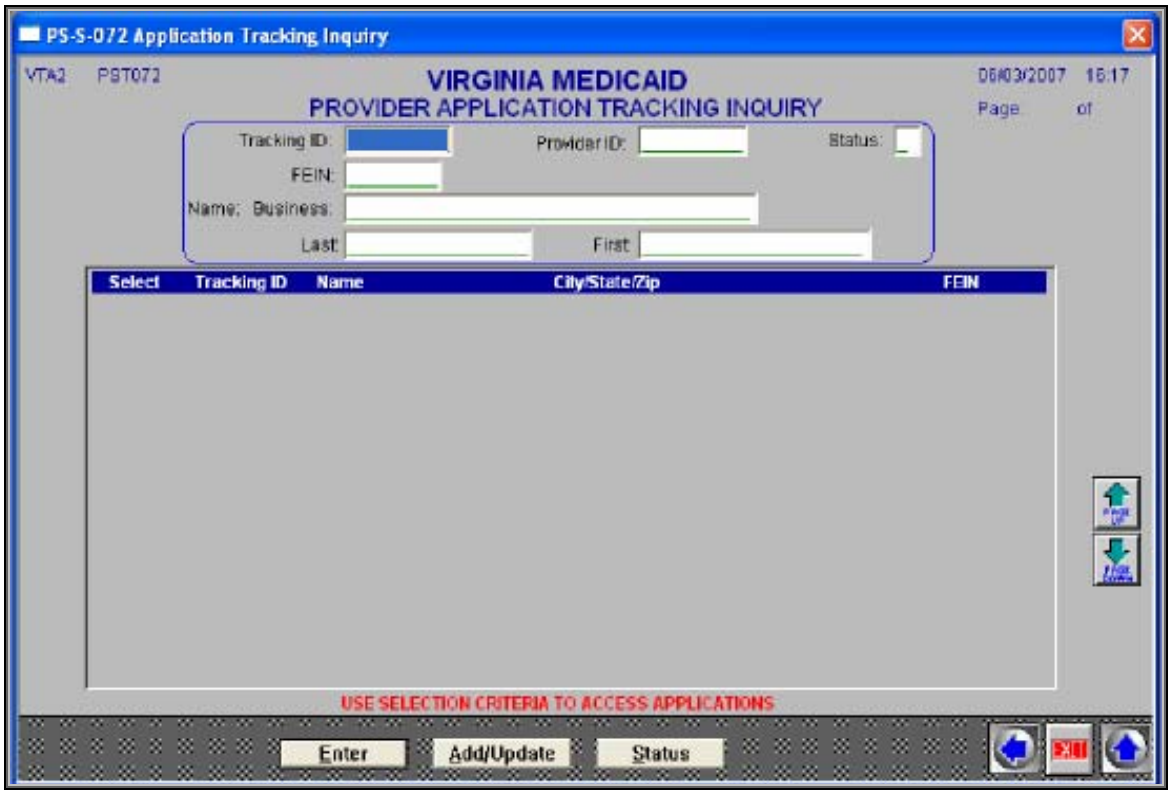
12.0 General Information (Provider Application Tracking Inquiry)

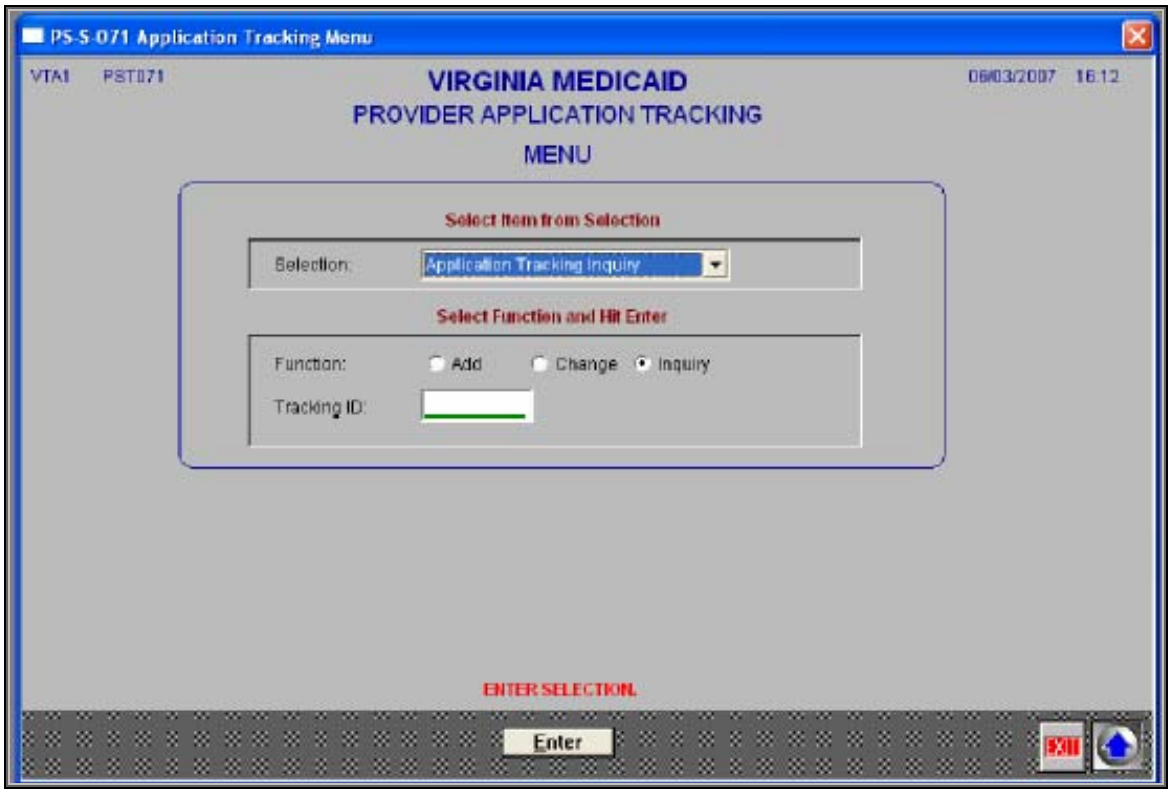
The Application Tracking Inquiry Screen is used to select a provider's application by Tracking Number, Name, and Provider ID, Status or IRS (FEIN) Number or a combination of selection criteria with status. Partial search keys of Provider Alternate ID value (DE 4044), Last Name of Provider (DE 4085), First Name of Provider (DE 4085), and Business name of Provider (DE 4085) must be at least three characters. The screen may be accessed with no Application Tracking Number (DE 4008), a partial Application Tracking Number (DE 4008) at least 7 bytes in length, or a full Application Tracking Number (DE 4008). Provider Application Status (DE 4282) may be used as the sole search criteria as well, but only Pending is accepted as a search value.

12.1 Screen Access (Provider Application Tracking Inquiry)

1. From the **Provider Application Tracking** menu, select **Application Tracking Inquiry** from the drop-down menu in the **Selection** field and Inquiry as the radio button in the **Function** field.
2. You may leave the **Tracking ID** field bank or enter at the minimum a 7-byte partial key for Application Tracking Number (DE 4008). If a partial or greater key is entered, it must be valid.
3. Choose **Enter** to see the results of the search.

   Note: If no Application Tracking Number was entered, the Application Tracking Inquiry screen will be displayed with the message "USE SELECTION CRITERIA TO ACCESS APPLICATIONS." Populate the field by which you would like to search the provider application.


PS-S-072 Application Tracking Inquiry
VTA2 PST072
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING INQUIRY
06/03/2007 16:17
Page of
Tracking ID:
Provider ID:
Status:
FEIN:
Name: Business:
Last:
First
Select
Tracking ID
Name
City/State/Zip
FEIN
USE SELECTION CRITERIA TO ACCESS APPLICATIONS
Enter
Add/Update
Status
EXIT


PS-S-071 Application Tracking Menu
VTA1 PST071
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING
MENU
06/03/2007 16:12
Select Item from Selection
Selection:
Application Tracking Inquiry
Select Function and Hit Enter
Function:
Add
Change
Inquiry
Tracking ID:
ENTER SELECTION.
Enter
EXIT

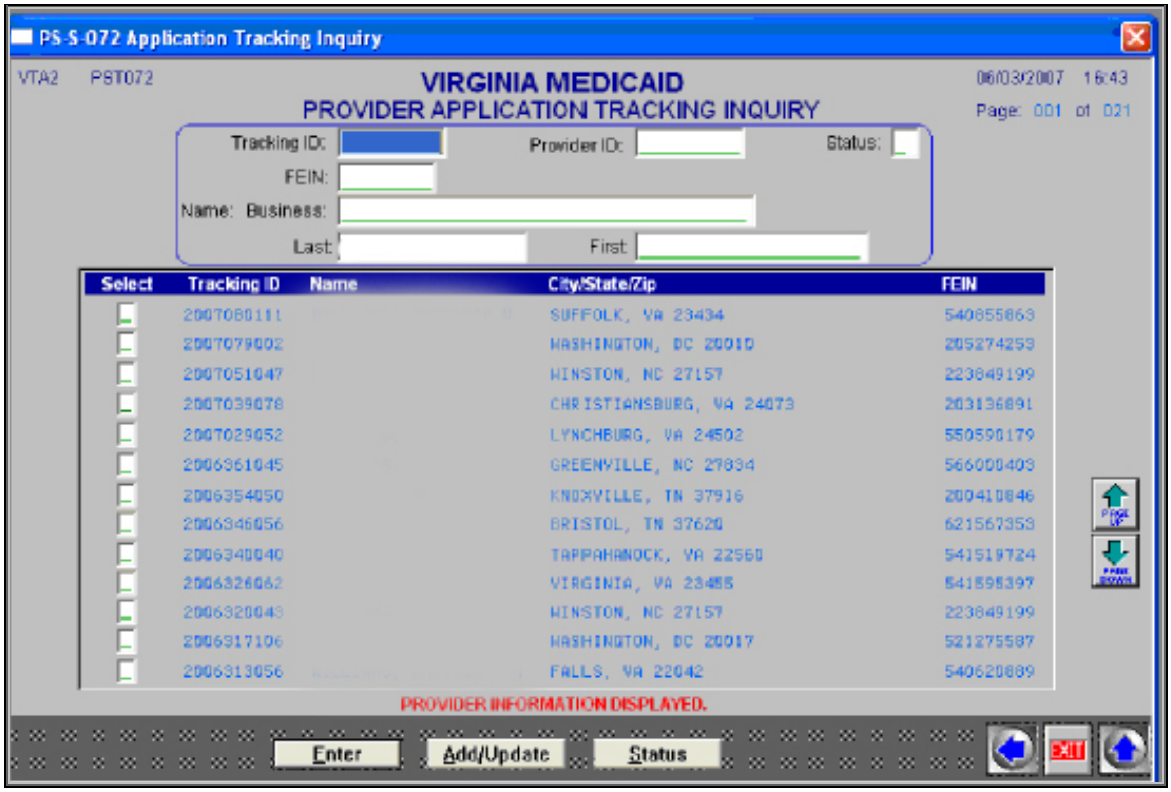
12.2 Enter Provider Data (Provider Application Tracking Inquiry)

1. After all data has been entered, click **Enter** to view edits.
2. Correct any errors.
3. Click **Enter**.

Screen	Data Element	Description	Value You Key	Comments
PS-S-072	Tracking ID	Displays the new sequence number generated to make the Provider Application Tracking Number unique in the Provider Application Tracking (PS _APPL _TRACK) database. The Application Number must be at least 7 bytes in length. These selection criteria can only be combined with status, and takes precedence over any selection criteria entered on the screen.	Enter a valid Application Tracking Number, must be at least 7 bytes in length.	N/A
PS-S-072	Provider ID	A unique identification number assigned to the servicing or billing provider. Can be a NPI/API or a Legacy	Enter a valid Provider ID Number.	N/A

Screen	Data Element	Description	Value You Key	Comments
PS-S-072	Status	Displays the provider application status code. Must be a valid status code. ("A" Approved, "D" Denied, "P" Pending, "R" Rejected)If used as the sole search criteria, it can only contain a value of "P" Pending. This is the only selection criteria on the screen that may be combined with the other selection criteria available.	Enter a valid Status code. ("A" Approved, "D" Denied, "P" Pending, "R" Rejected) If used as the sole search criteria, it can only contain a value of "P" Pending.	N/A
PS-S-072	FEIN	The federal employer identification number for the provider	Enter a valid FEIN. Must be at least 3 characters long on a partial search	All other search criteria must be blank with the exception of status, if using FEIN as the main selection criteria.
PS-S-072	Business	Displays the business name of the provider	Enter a valid Business name. The Business name must be at least three characters long on a partial search.	The business name must be at least three characters long. All other search criteria must be blank with the exception of status, if using business name as the main selection criteria.
PS-S-072	Last	Displays the last name of the provider	Enter a valid Last name. The last name must be at least three characters long.	All other search criteria must be blank with the exception of status, if using last name as the main selection criteria.

Screen	Data Element	Description	Value You Key	Comments
PS-S-072	First	Displays the first name of the provider	Enter a valid First name. The first name must be at least three characters long.	When combined with last name, the first name must be at least one character long. All other search criteria must be blank with the exception of status and last name, if using first name as the main selection criteria. When combined with last name, the first name must be at least one character long.
PS-S-072	Select	Displays the selection field used to select a specific application tracking number	N/A	System displayed
PS-S-072	Tracking ID	Displays the new sequence number generated to make the Provider Application Tracking Number unique in the Provider Application Tracking (PS_APPL_TRACK) database	N/A	System displayed
PS-S-072	City	City name for the provider	N/A	System displayed
PS-S-072	State	State name for the provider	N/A	System displayed
PS-S-072	Zip	Provider zip code	N/A	System displayed
PS-S-072	FEIN	The federal employer identification number for the provider	N/A	System displayed



12.3 Error Messages (Provider Application Tracking Inquiry)

Screen	Error	Description	Value You Key	Comments
PS-S-072	42	ACCESS TO THE PROGRAM IS NOT AUTHORIZED	N/A	User does not have access to the screens chosen.
PS-S-072	8841	APPLICATION TRACKING RECORD HAS NOT BEEN SELECTED, FUNCTION KEY INVALID	Select Application Tracking record.	Information message
PS-S-072	8851	APPLICATION TRACKING STATUS MUST EQUAL P	Enter P in Application Tracking Status field.	Information message
PS-S-072	8828	APPLICATION TRACKING STATUS MUST EQUAL P, R, D, OR A	Enter a valid status code	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-072	8853	BUSINESS NAME SELECTION CRITERIA MUST BE AT LEAST 3 CHARACTERS	Enter at least 3 characters for business name selection.	N/A
PS-S-072	68	DATA REFRESHED	N/A	Information message
PS-S-072	116	END OF LIST	N/A	Information message
PS-S-072	4	END OF THE PAGE	N/A	Information message
PS-S-072	4081	ENTER NUMERIC PROVIDER NUMBER	Enter valid values according to error message specifications.	N/A
PS-S-072	4497	ENTER VALID PROVIDER NUMBER FOR PROCESSING	Enter valid values according to error message specifications.	N/A
PS-S-072	10	ERROR OCCURRED AT RECEIVE; TRANSACTION CANCELLED	Retry the transaction, if necessary.	N/A
PS-S-072	11	ERROR OCCURRED AT SEND; TRANSACTION CANCELLED	Retry the transaction, if necessary.	N/A
PS-S-072	8852	FEIN SELECTION CRITERIA MUST BE AT LEAST 3 CHARACTERS	Enter at least 3 characters for FEIN selection.	N/A
PS-S-072	8856	FIRST NAME SELECTION CRITERIA MUST BE AT LEAST 1 CHARACTER WITH LAST NAME	Enter the last name and at least 1 character for first name selection.	N/A
PS-S-072	8854	FIRST NAME SELECTION CRITERIA MUST BE AT LEAST 3 CHARACTERS	Enter at least 3 characters for first name selection.	N/A
PS-S-072	15	FUNCTION CHOSEN IS INVALID	Choose another function.	N/A
PS-S-072	8816	IRS NUMBER INVALID	Enter a valid IRS number.	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-072	8855	LAST NAME SELECTION CRITERIA MUST BE AT LEAST 3 CHARACTERS	Enter at least 3 characters for last name selection.	N/A
PS-S-072	17	NEXT PAGE DATA IS DISPLAYED	N/A	Information message
PS-S-072	8849	NO APPLICATIONS FOUND FOR CRITERIA ENTERED	Re-enter proper criteria or exit application.	N/A
PS-S-072	20	PREVIOUS PAGE DATA IS DISPLAYED	N/A	Information message
PS-S-072	4098	PROVIDER INFORMATION DISPLAYED	N/A	Information message
PS-S-072	29	TOP OF THE PAGE	N/A	Information message
PS-S-072	67	UNABLE TO RETURN TO PREVIOUS PROGRAM, CHOOSE THE EXIT BUTTON TO CONTINUE	Choose the EXIT button to Continue processing.	N/A
PS-S-072	43	UNIDENTIFIED SECURITY ERROR	User not authorized for the transaction.	N/A
PS-S-072	8818	USE SELECTION CRITERIA TO ACCESS APPLICATIONS	Enter appropriate selection criteria.	N/A

13.0 General Information (Provider Application Add/Update)

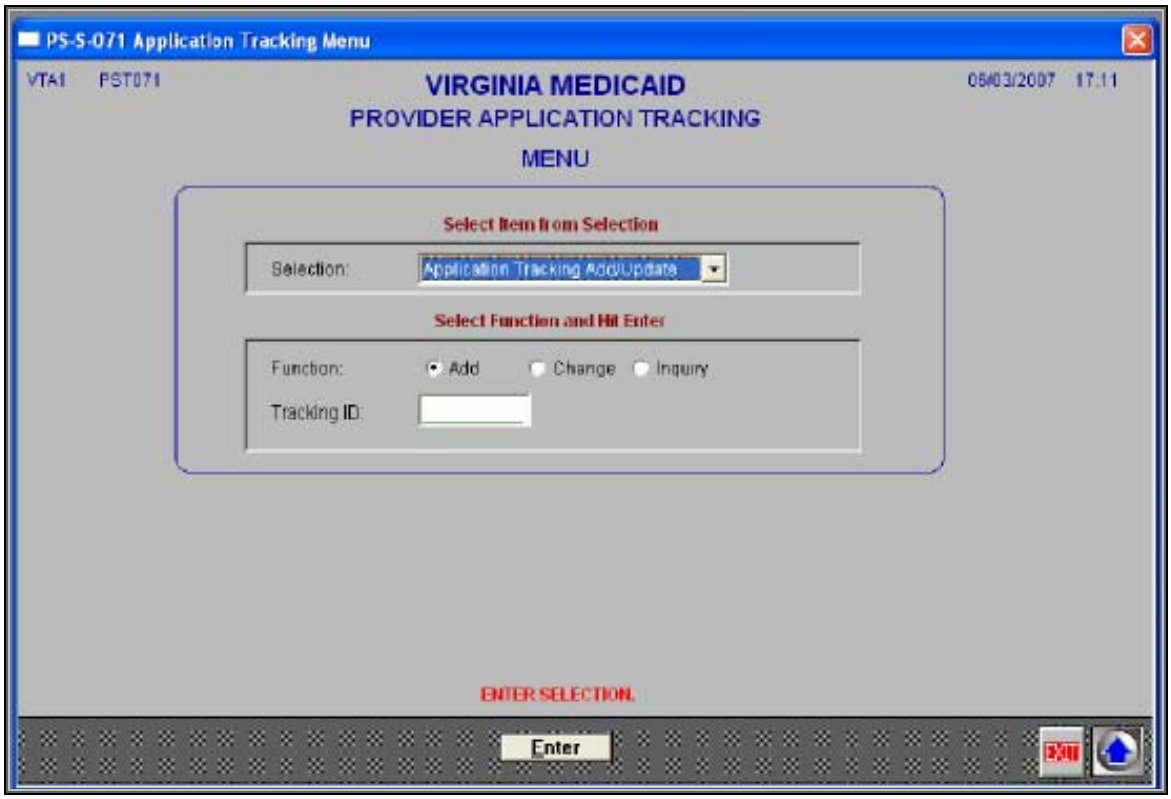
The Application Tracking Add/Update Screen is used to add the provider's application for enrollment from its receipt and to update the application if needed after it has been created. The Provider Application Status Code (DE 4282) is defaulted to a status of Pending, and the Provider Application Date (DE 4059) is defaulted to the current date when the application is created. The Provider Application Status Code (DE4282) determines what fields will be unprotected or protected for update, and can only be changed on the Provider Application Status Screen (PS-S-073). If the Provider Application is in a Status of Pending or Rejected all details are available for update. When the Provider Application is in a Status of Denied only address fields are available for update for correspondence purposes. If the Provider Application is in a Status of Approved, no details are available for update Choose Enter when all the information is entered for add or update. If no errors occur, choose the Update button on the bottom of the screen.

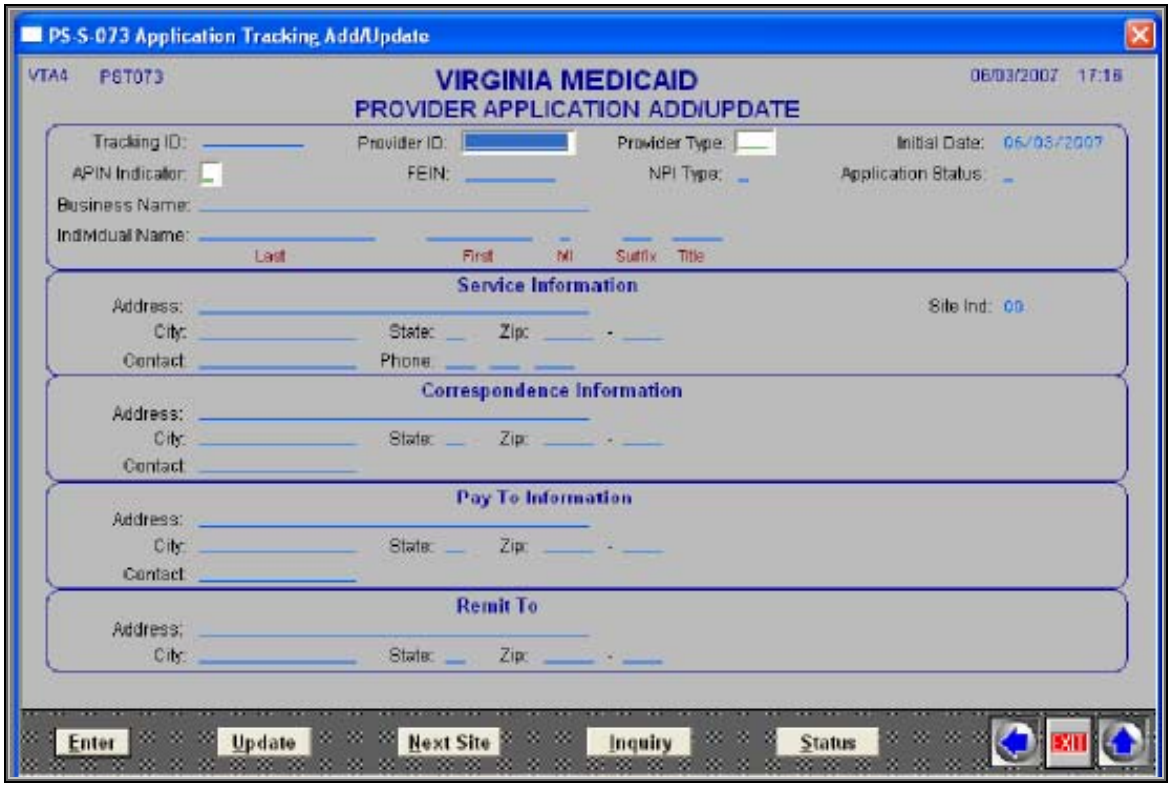
13.1 Screen Access (Provider Application Add/Update)

From the Provider Application Tracking Menu:

1. Choose **Application Tracking Add/Update** in the drop-down menu.
2. Choose the function desired. For a new application, leave the **Tracking ID** field blank, the Provider Application number will be populated on the Provider Application Tracking screen once the Provider's application has been successfully entered in the database. For an existing application, enter the **Provider Application Number** in the **Tracking ID** value field.
3. Select **Enter**.

   Note: In Update mode, if you make no entry in the Tracking ID Value field of the Provider Application Tracking Main Menu, you must enter the Tracking ID on the Provider Application Tracking Add/Update screen and press Enter to display the record.


PS-S-071 Application Tracking Menu
VTA1 PST071
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING
MENU
05/03/2007 17:11
Select Item from Selection
Selection:
Application Tracking Add/Update
Select Function and Hit Enter
Function:
Add
Change
Inquiry
Tracking ID:
ENTER SELECTION.
Enter
EXIT


PS-S-073 Application Tracking Add/Update
VTA4 PST073
VIRGINIA MEDICAID
PROVIDER APPLICATION ADD/UPDATE
06/03/2007 17:16
Tracking ID:
Provider ID:
Provider Type:
Initial Date: 06/03/2007
APIN Indicator:
FEIN:
NPI Type:
Application Status:
Business Name:
Individual Name:
Last
First
MI
Suffix
Title
Service Information
Address:
Site Ind: 00
City:
State:
Zip:
Contact:
Phone:
Correspondence Information
Address:
City:
State:
Zip:
Contact:
Pay To Information
Address:
City:
State:
Zip:
Contact:
Remit To
Address:
City:
State:
Zip:
Enter
Update
Next Site
Inquiry
Status
EXIT

13.2 Entering Provider Data (Provider Application Add/Update)

1. After all data has been entered, click **Enter** to view edits.
2. If no edits are returned, click **Update**.
3. If errors are returned, make corrections.
4. Click **Enter** and then **Update**.

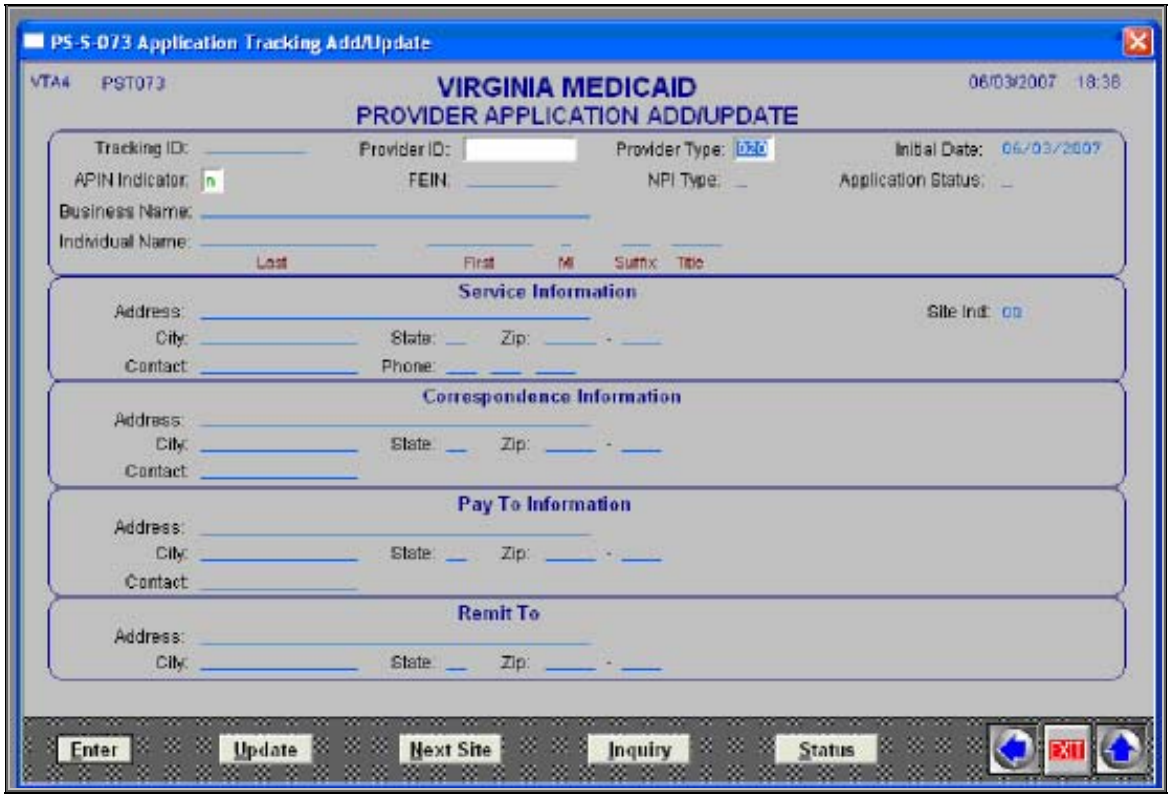
Screen	Data Element	Description	Value You Key	Comments
PS-S-073	Tracking ID	Displays the new sequence number generated to make the Provider Application Tracking Number unique in the Provider Application Tracking database when a new provider application is created using the ADD transaction. If entered on a Change transaction, the Provider Application Number must equal an existing Provider Application Number.	ADD: System generated and displayed. A new sequence number is created for each Provider Application entered into the system. UPDATE: Enter a valid Provider Application Tracking Number.	N/A
PS-S-073	Provider ID	A unique identification number assigned to the servicing or billing provider.	Enter the provider's 10 digit NPI if the provider is considered a healthcare provider. Leave blank if the provider is considered atypical.	N/A
PS-S-073	Provider Type	A code that designates the classification of a provider under the State plan	Enter a valid Provider Type.	Use the online help to find the valid Provider Type for the provider.

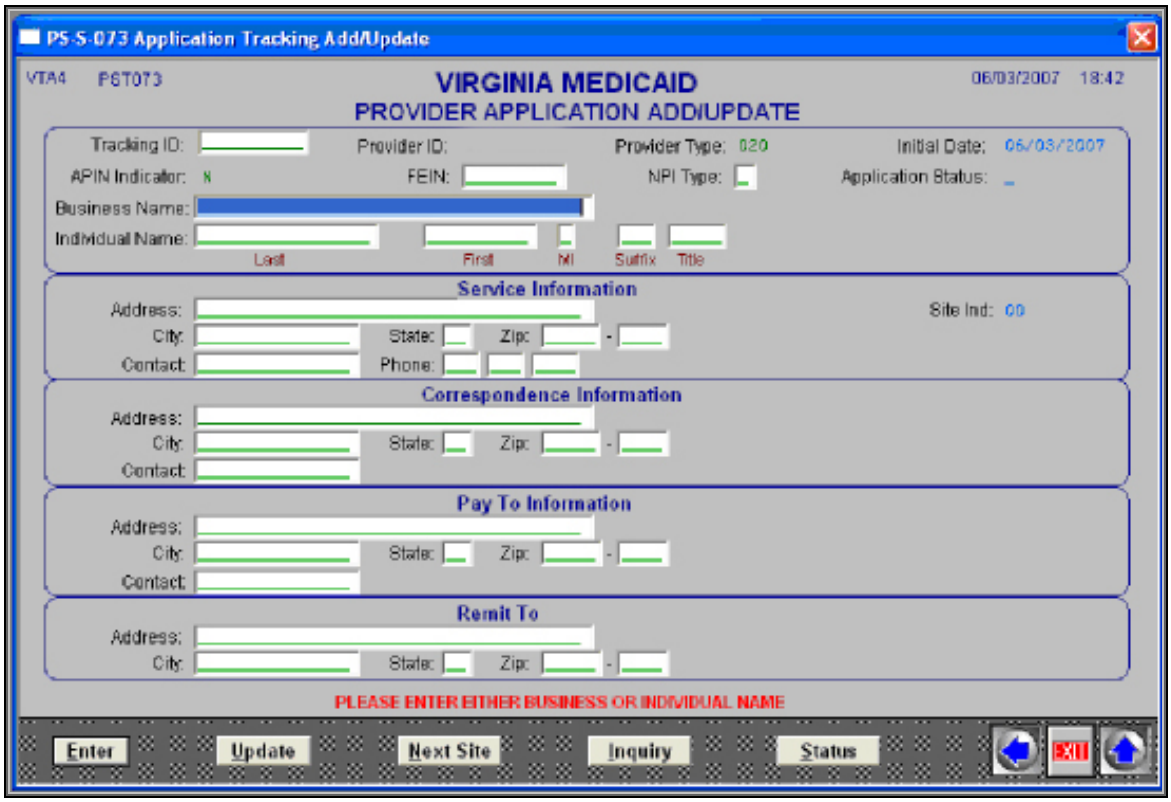
Screen	Data Element	Description	Value You Key	Comments
PS-S-073	NPI Type	Displays the NPI Type. NPI Type 1 indicates Individual and 2 indicates Organization.	Enter a valid NPI Type.	N/A
PS-S-073	Initial Date	Displays the date that the application was entered into the system.	N/A	System Displayed.
PS-S-073	APIN Indicator	Displays the APIN Indicator that determines if the Provider Application Number is eligible to have correspondence sent out. The APIN Indicator will default to 'N' if not entered.	Enter “Y” if enrolling a Provider Type 10 (APIN) provider.	N/A
PS-S-073	FEIN	Displays the social security number of the employee or the federal employer identification number for the insurance carrier, employer, or other entity	Enter a valid SSN or FEIN.	Must be numeric and nine characters long
PS-S-073	Application Status	Displays the provider application status code. Defaults to “P”	N/A	Must be a valid status code. ("A" Approved, "D" Denied, "P" Pending, "R" Rejected)

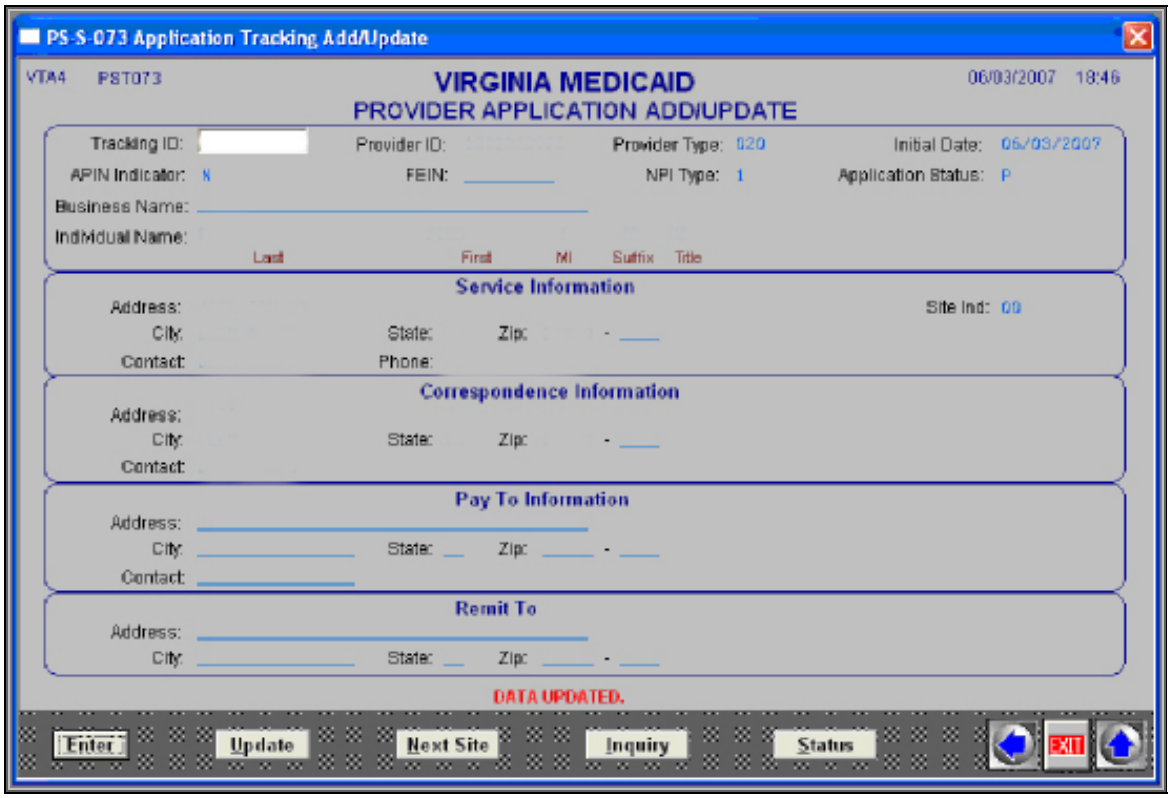
Screen	Data Element	Description	Value You Key	Comments
PS-S-073	Business Name	Displays the business name of the provider. Either the business name or provider name must be entered on the application.	Enter a valid business name if the enrolling provider is a business entity.	Either the business name or provider name must be entered on the provider application. These fields can only be updated when the provider application is in a status of Pending or Rejected.
PS-S-073	Last	Displays the last name of the provider	Enter a valid Last name.	Either the provider last name and first name must be populated or the business name must be populated.
PS-S-073	First	Displays the first name of the provider	Enter a valid First name.	Either the provider last name and first name must be populated or the business name must be populated.
PS-S-073	MI	Displays the middle initial of the provider name	Enter a valid Middle Initial.	The providers last and first name must be populated along with the business name being blank in order for this field to be populated.
PS-S-073	Suffix	Displays the suffix of the provider name	Enter a valid Suffix.	The providers last and first name must be populated along with the business name being blank in order for this field to be populated.

Screen	Data Element	Description	Value You Key	Comments
PS-S-073	Title	Displays the title of the provider name	Enter a valid Title.	The providers last and first name must be populated along with the business name being blank in order for this field to be populated.
PS-S-073	Address	The service address line of the servicing provider.	Enter a valid Provider Address.	Service Information
PS-S-073	City	The service city of the servicing provider	Enter a valid Provider City Delivery Address.	Service Information
PS-S-073	State	The service state of the servicing provider	Enter a valid Provider State Delivery Address.	Service Information
PS-S-073	Zip Code	The service ZIP Code of the servicing provider	Enter a valid Provider ZIP CODE.	Service Information
PS-S-073	Contact	The individual person to contact at the servicing location	Enter a valid Provider Contact Name.	Service Information
PS-S-073	Phone	The number indicating the phone number of the individual listed as the contact.	Enter a valid Phone Number.	Service Information
PS-S-073	Address	The correspondence address line of the servicing provider.	Enter a valid Provider Address.	Correspondence Information
PS-S-073	City	The correspondence city of the servicing provider	Enter a valid Provider City Delivery Address.	Correspondence Information
PS-S-073	State	The correspondence state of the servicing provider	Enter a valid Provider State Delivery Address.	Correspondence Information
PS-S-073	Zip Code	The correspondence ZIP Code of the servicing provider	Enter a valid Provider ZIP CODE.	Correspondence Information

Screen	Data Element	Description	Value You Key	Comments
PS-S-073	Contact	The individual person to contact at the correspondence location	Enter a valid Provider Contact Name.	Correspondence Information
PS-S-073	Address	The pay to address line of the servicing provider	Enter a valid Provider Address.	Pay To Information
PS-S-073	City	The pay to city of the servicing provider	Enter a valid Provider City Delivery Address.	Pay To Information
PS-S-073	State	The pay to state of the servicing provider	Enter a valid Provider State Delivery Address.	Pay To Information
PS-S-073	Zip Code	The pay to ZIP Code of the servicing provider	Enter a valid Provider ZIP CODE.	Pay To Information
PS-S-073	Contact	The individual person to contact at the pay to location	Enter a valid Provider Contact Name.	Pay To Information
PS-S-073	Address	The remit to address line of the servicing provider	Enter a valid Provider Address.	Remit To Information
PS-S-073	City	The remit to city of the servicing provider	Enter a valid Provider City Delivery Address.	Remit To Information
PS-S-073	State	The remit to state of the servicing provider	Enter a valid Provider State Delivery Address.	Remit To Information
PS-S-073	Zip Code	The remit to ZIP Code of the servicing provider	Enter a valid Provider ZIP CODE.	Remit To Information


PS-S-073 Application Tracking Add/Update
VTA4 PST073
VIRGINIA MEDICAID
PROVIDER APPLICATION ADD/UPDATE
06/03/2007 18:38
Tracking ID:
Provider ID:
Provider Type: 020
Initial Date: 06/03/2007
APIN Indicator: n
FEIN:
NPI Type:
Application Status:
Business Name:
Individual Name:
Last
First
MI
Suffix
Title
Service Information
Address:
Site Ind: 00
City:
State:
Zip:
Contact:
Phone:
Correspondence Information
Address:
City:
State:
Zip:
Contact:
Pay To Information
Address:
City:
State:
Zip:
Contact:
Remit To
Address:
City:
State:
Zip:
Enter
Update
Next Site
Inquiry
Status
EXIT


PS-S-073 Application Tracking Add/Update
VTA4 PST073
VIRGINIA MEDICAID
PROVIDER APPLICATION ADD/UPDATE
06/03/2007 18:42
Tracking ID:
Provider ID:
Provider Type: 020
Initial Date: 06/03/2007
APIN Indicator: N
FEIN:
NPI Type:
Application Status:
Business Name:
Individual Name:
Last
First
MI
Suffix
Title
Service Information
Address:
Site Ind: 00
City:
State:
Zip:
Contact:
Phone:
Correspondence Information
Address:
City:
State:
Zip:
Contact:
Pay To Information
Address:
City:
State:
Zip:
Contact:
Remit To
Address:
City:
State:
Zip:
PLEASE ENTER EITHER BUSINESS OR INDIVIDUAL NAME
Enter
Update
Next Site
Inquiry
Status
EXIT



13.3 Error Messages (Provider Application Add/Update)

Screen	Error	Description	Value You Key	Comments
PS-S-073	42	ACCESS TO THE PROGRAM IS NOT AUTHORIZED	User does not have access to the screens chosen.	N/A
PS-S-073	9955	APIN INDICATOR - DEFAULT VALUE IS "N"	N/A	Informational message
PS-S-073	8825	APPLICATION TRACKING NUMBER ALREADY EXISTS	N/A	Informational message
PS-S-073	8826	APPLICATION TRACKING NUMBER ALREADY EXISTS ON STATUS TABLE	N/A	Informational message
PS-S-073	8824	APPLICATION TRACKING NUMBER NOT NUMERIC	Enter a valid numeric Application tracking number.	N/A
PS-S-073	8828	APPLICATION TRACKING STATUS MUST EQUAL P, R, D, OR A	Enter a valid status code	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-073	4435	BEGIN DATE MUST BE LESS THAN END DATE	Correct field value if keyed incorrectly. Otherwise, accept transaction with errors to generate TAD.	N/A
PS-S-073	9915	CANNOT BRANCH TO PROV INFO SCREEN AS THE ID SELECTED IS A VENDOR PAYEE	The Prov. Info button should not pressed if the Payee ID value on the screen is a Vendor Payee ID	N/A
PS-S-073	39	CHOOSE UPDATE TO SAVE CHANGES	Choose the update button to save the changes.	N/A
PS-S-073	9949	CORRESPONDENCE ADDRESS MUST BE ENTERED	Enter the correspondence address.	N/A
PS-S-073	9951	CORRESPONDENCE CITY MUST BE ENTERED	Enter the correspondence address's city.	N/A
PS-S-073	9952	CORRESPONDENCE STATE MUST BE ENTERED	Enter the correspondence address's state.	N/A
PS-S-073	9953	CORRESPONDENCE ZIP MUST BE ENTERED	Enter the correspondence address's zip code.	N/A
PS-S-073	3056	DATA DISPLAYED	N/A	Informational message
PS-S-073	68	DATA REFRESHED	N/A	Informational message
PS-S-073	27	DATA UPDATED	N/A	N/A
PS-S-073	4622	ENTER A VALID PHONE NUMBER	Enter valid values according to error message specifications.	N/A
PS-S-073	4081	ENTER NUMERIC PROVIDER NUMBER	Enter valid values according to error message specifications.	N/A
PS-S-073	10	ERROR OCCURRED AT RECEIVE; TRANSACTION CANCELLED	Retry the transaction, if necessary.	N/A
PS-S-073	11	ERROR OCCURRED AT SEND; TRANSACTION CANCELLED	Retry the transaction, if necessary.	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-073	9958	FEIN MUST BE UNIQUE FOR NPI TYPE 1	Enter different FEIN to continue or go back to previous screen.	N/A
PS-S-073	9959	FEIN NOT UNIQUE IN MMIS	Enter different FEIN.	N/A
PS-S-073	15	FUNCTION CHOSEN IS INVALID	Choose another function.	N/A
PS-S-073	8845	INCOMPLETE ADDRESS INFORMATION, NOT ALL FIELDS POPULATED	Enter the required fields.	N/A
PS-S-073	4698	INVALID ENTRY FOR SERVICING ADDRESS	Check field for valid data and re-enter.	N/A
PS-S-073	8900	INVALID NPI TYPE, SHOULD BE 1 OR 2 OR BLANK	Enter 1 or 2 or spaces in the NPI TYPE field.	N/A
PS-S-073	8816	IRS NUMBER INVALID	Enter a valid IRS number.	N/A
PS-S-073	8820	MAIL ZIP EXTENSION CAN NOT BE POPULATED WITHOUT A MAIL ZIP	Enter the mailing address zip code before entering the zip code extension.	N/A
PS-S-073	17	NEXT PAGE DATA IS DISPLAYED	N/A	Informational message
PS-S-073	9963	NEXT SITE IS ONLY VALID FOR ADDS AND CHANGES	N/A	Informational message
PS-S-073	9968	NEXT SITE NOT AVAILABLE FOR NEW NPI PROVIDERS	N/A	Informational message
PS-S-073	9967	NEXT SITE ONLY WORKS WHEN PROV ID IS FILLED IN	Enter Prov. Id values to view next site details.	N/A
PS-S-073	9966	NEXT SITE SERVICE ADDRESS DISPLAYED	N/A	Informational message
PS-S-073	4437	NO RECORDS FOUND RETURN TO MAIN MENU TO ADD A PROVIDER APPLICATION.	N/A	Informational message

Screen	Error	Description	Value You Key	Comments
PS-S-073	7066	NOTHING TO UPDATE; DATA HAS NOT CHANGED	N/A	Informational message
PS-S-073	8874	NPI NOT FOUND	NPI not on database	N/A
PS-S-073	8899	NPI NOT UNIQUE; VERIFY DATA OR CHOOSE UPDATE TO SAVE CHANGES	N/A	Informational message
PS-S-073	8914	NPI TYPE 1 (INDIVIDUAL) HAS BUSINESS NAME. VERIFY DATA AND CONTINUE.	N/A	Informational message
PS-S-073	8917	NPI TYPE 2 (ORGANIZATION) HAS INDIVIDUAL NAME.VERIFY DATA AND CONTINUE.	N/A	Informational Message
PS-S-073	8843	ONLY "Y" OR "N" MAY BE ENTERED FOR APIN INDICATOR	Enter value 'Y' or 'N' only.	N/A
PS-S-073	8821	PAY ZIP EXTENSION CAN NOT BE POPULATED WITHOUT A PAY ZIP	Enter the pay-to address zip code before entering the zip code extension.	N/A
PS-S-073	4044	PHONE NUMBER IS INVALID	N/A	Informational message
PS-S-073	8912	PLEASE ENTER 10 DIGIT NUMERIC PROVIDER ID.	N/A	Informational message
PS-S-073	8827	PLEASE ENTER A VALID TRACKING NUMBER	N/A	Informational message
PS-S-073	8817	PLEASE ENTER APPLICATION TRACKING NUMBER	Enter the application tracking number.	N/A
PS-S-073	8809	PLEASE ENTEREITHER BUSINESS OR INDIVIDUAL NAME	Enter either the business or the individual name for the provider.	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-073	8800	PROGRAM CODE 10 CANNOT OVERLAP WITH OTHER PROGRAM CODES DATES.	Correct the Program code segments so that Program code 10 does not overlap with other Program codes.	N/A
PS-S-073	9948	PROV ID AND TYPE EXIST – CANNOT BE ADDED AGAIN	Exit the transaction.	N/A
PS-S-073	4135	PROVIDER APPLICATION STATUS CODE IS INVALID	N/A	Informational message
PS-S-073	4098	PROVIDER INFORMATION DISPLAYED	N/A	Informational message
PS-S-073	9947	PROVIDER IS TYPICAL – NPI MUST BE ENTERED	Enter the NPI number.	N/A
PS-S-073	4165	PROVIDER TYPE NOT FOUND	Enter a valid Provider Type.	N/A
PS-S-073	4168	PROVIDER TYPE REQUIRED	Enter an RA end date falling before the Service Center End date.	N/A
PS-S-073	8822	REMIT ZIP EXTENSION CAN NOT BE POPULATED WITHOUT REMIT ZIP	Enter the remit- to address zip code before entering the zip code extension.	N/A
PS-S-073	8810	SERVICE ADDRESS MUST BE ENTERED	Enter the service address.	N/A
PS-S-073	8811	SERVICE CITY MUST BE ENTERED	Enter the service address's city.	N/A
PS-S-073	8812	SERVICE STATE MUST BE ENTERED	Enter the service address's state.	N/A
PS-S-073	8819	SERVICE ZIP EXTENSION CAN NOT BE POPULATED WITHOUT A SERVICE ZIP	Enter the service address zip code before entering the zip code extension.	N/A
PS-S-073	8814	SERVICE ZIP EXTENSION MUST BE ENTERED	Enter the service address's zip code extension.	N/A
PS-S-073	8813	SERVICE ZIP MUST BE ENTERED	Enter the service address's zip code.	N/A
PS-S-073	4349	STATE IS INVALID	Information message	N/A

Screen	Error	Description	Value You Key	Comments
PS-S-073	67	UNABLE TO RETURN TO PREVIOUS PROGRAM, CHOOSE THE EXIT BUTTON TO CONTINUE	Choose the EXIT button to Continue processing.	N/A
PS-S-073	43	UNIDENTIFIED SECURITY ERROR	N/A	User not authorized for the transaction.
PS-S-073	8818	USE SELECTION CRITERIA TO ACCESS APPLICATIONS	Enter appropriate selection criteria.	N/A
PS-S-073	4045	ZIP CODE IS INVALID	Enter a valid ZIP code. See the field definitions for explanation and formatting requirements.	N/A

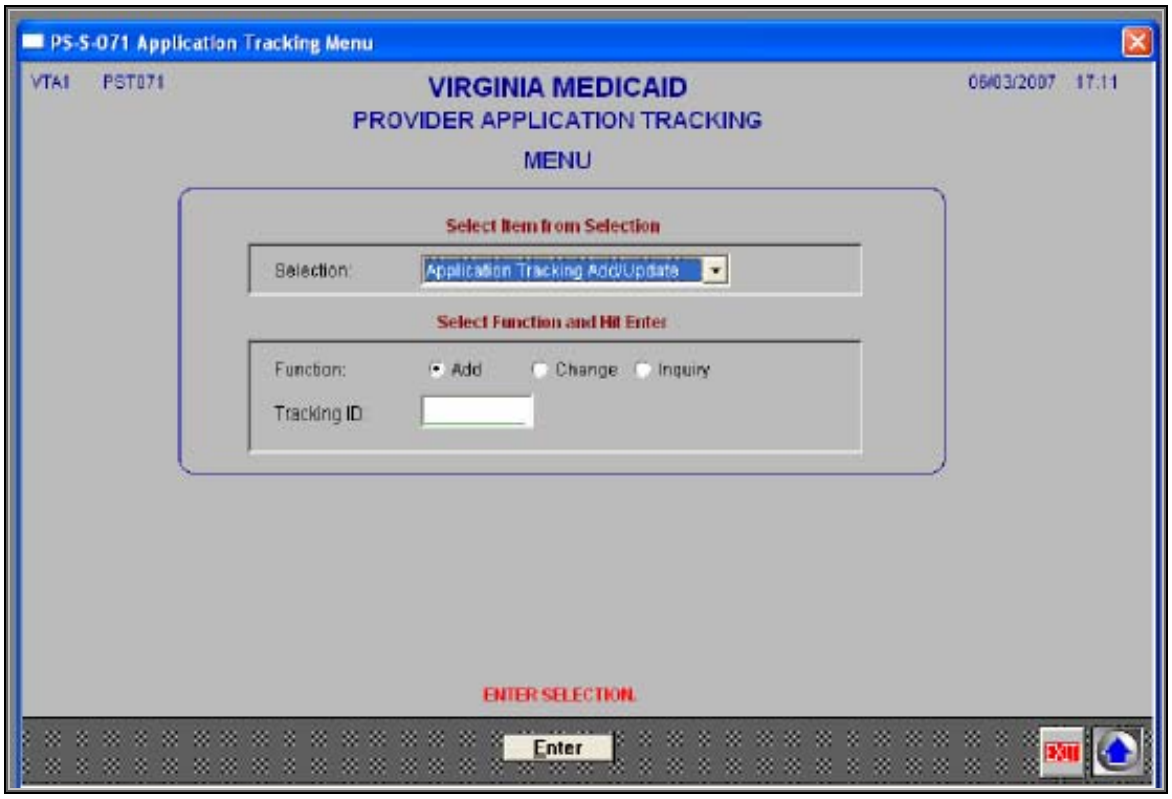
14.0 General Information (Provider Application Approval)

The Application Tracking Status Screen is used to modify the provider's application for enrollment status to its final disposition. Their may be more than one Provider Application Status entry per Provider Application Tracking Number. Whenever a Provider Application Status entry changes from a rejected status, or the reason codes are modified on a rejected status entry a new Provider Application Status Record is created. Only the Provider Application Status and Reason Codes may be modified for a Provider Application Status entry that is in a Pending or Rejected Status. Once the Provider Application Status entry is approved, a Provider ID is created and the all fields are protected so that no further modifications can be made. This is also true for a Denied Provider Application Status entry; no fields are available for edit. The only data field that can be modified regardless of status is the letter sent indicator of the current Provider Application Record.

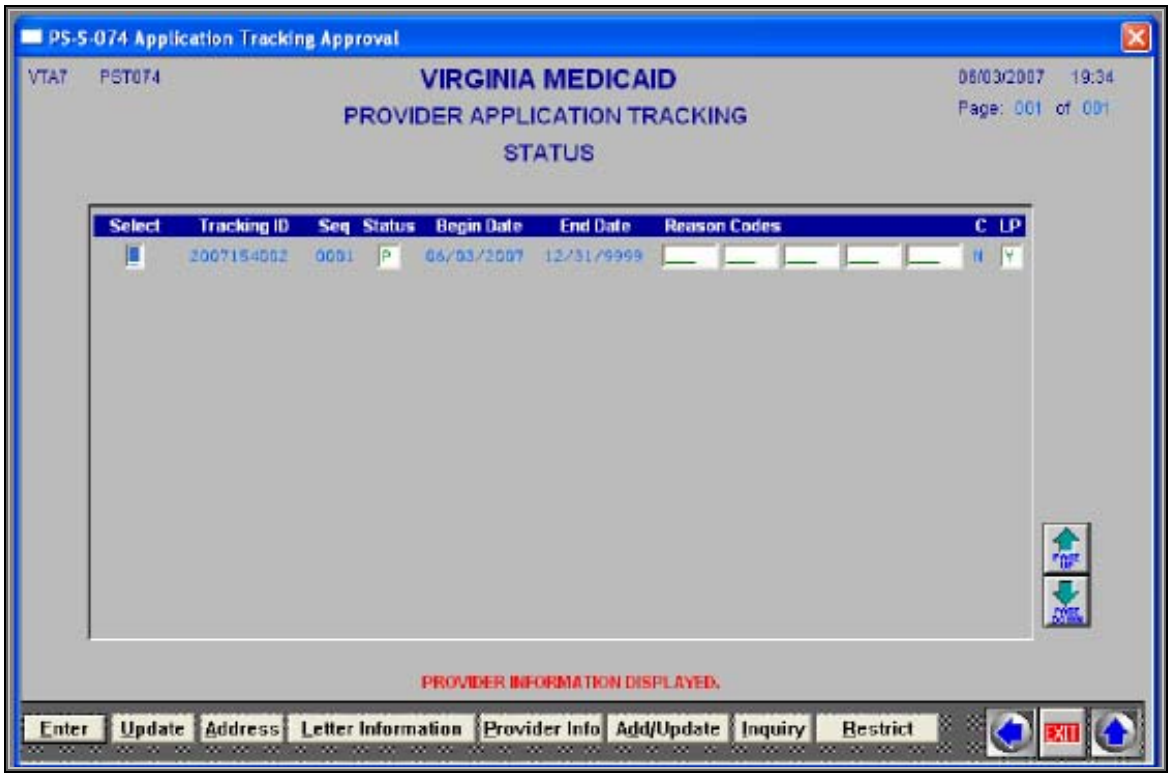
14.1 Screen Access (Provider Application Approval)

From the Provider Application Tracking Menu:

1. Choose **Application Tracking Approval** in the drop-down menu in the **Selection** field, and Inquiry or change as the radio button in the **Function** field.
2. A minimum of a 7-byte partial key for Application Tracking Number is required in the Tracking ID field. The Provider Application Tracking Number must be valid.
3. Choose **Enter** to view the **Provider Application Tracking Status** screen (PS-S074).


PS-S-071 Application Tracking Menu
VTAI PST071
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING
MENU
06/03/2007 17:11
Select Item from Selection
Selection: Application Tracking Add/Update
Select Function and Hit Enter
Function: Add Change Inquiry
Tracking ID:
ENTER SELECTION
Enter
EXIT

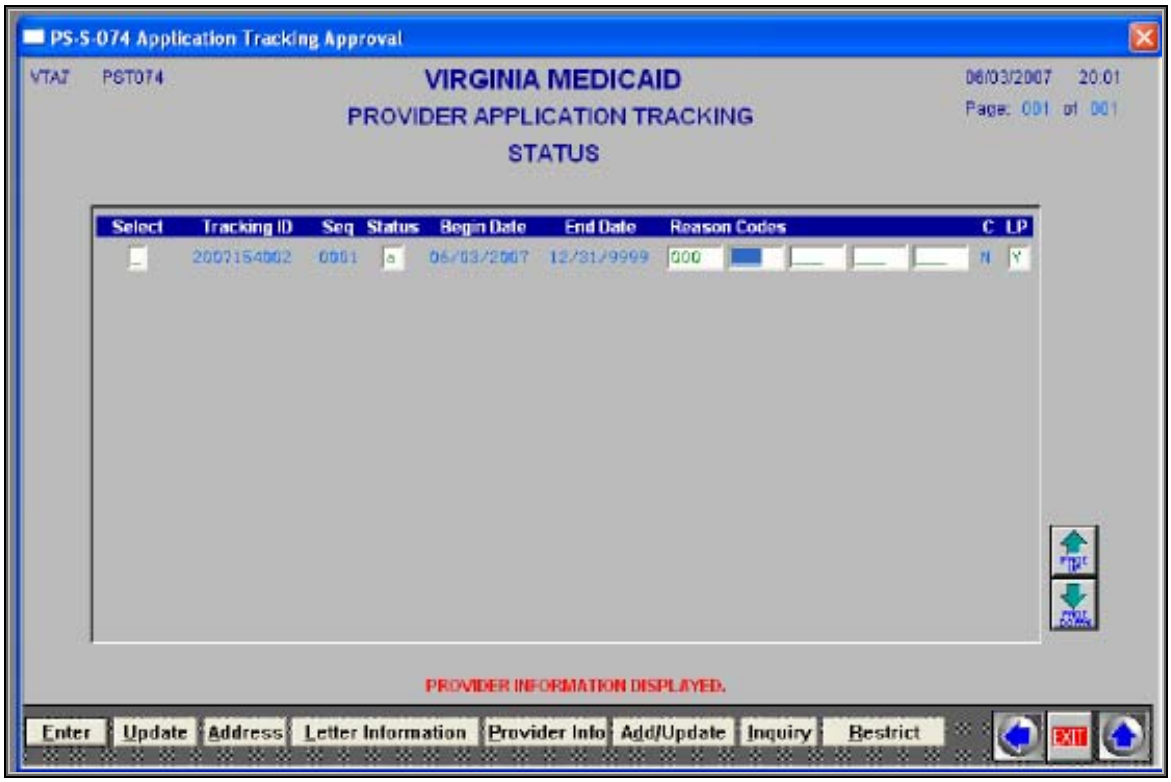
PS-S-071 Application Tracking Menu
VTAI PST071
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING
MENU
06/03/2007 19:33
Select Item from Selection
Selection: Application Tracking Approval
Select Function and Hit Enter
Function: Add Change Inquiry
Tracking ID: 2007154002
ENTER SELECTION
Enter
EXIT

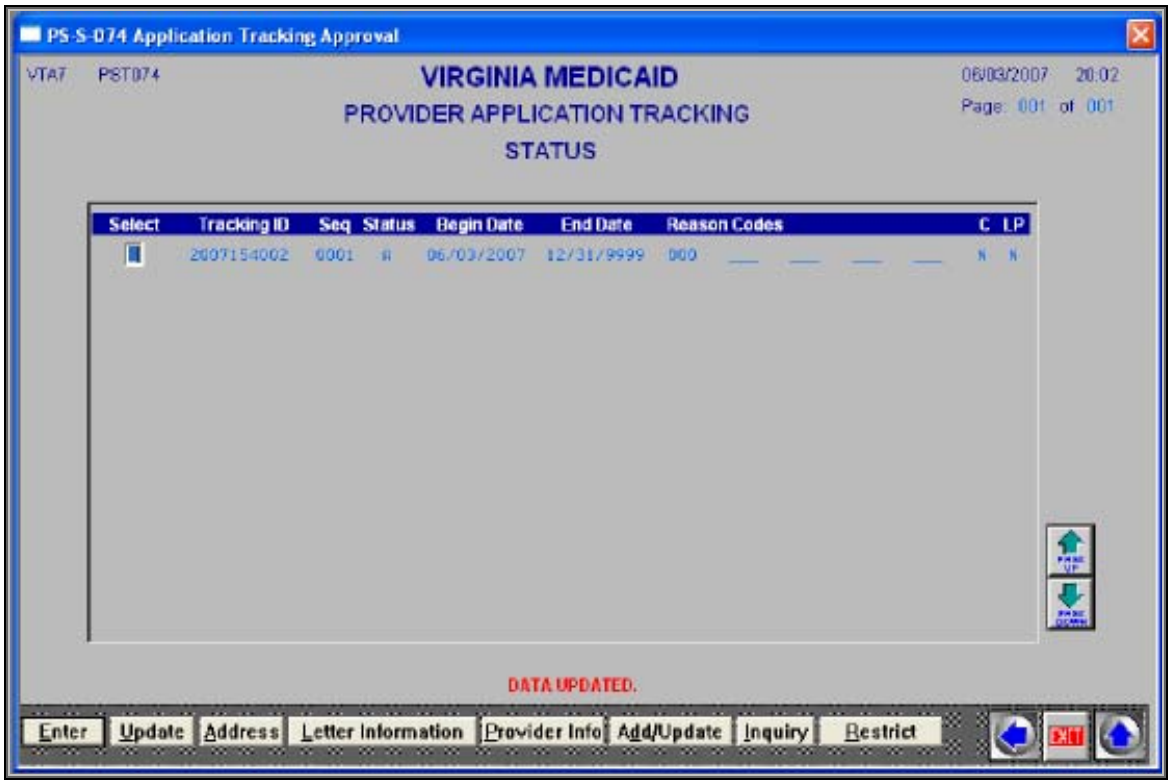


14.2 Enter Provider Data (Provider Application Approval)

Screen	Data Element	Description	Value You Key	Comments
PS-S-074	Select	Displays the selection field used to select a specific application tracking number	N/A	N/A
PS-S-074	Tracking ID	Displays the new sequence number generated to make the Provider Application Tracking Number unique in the Provider Application Tracking database when a new provider application is created.	N/A	System displayed
PS-S-074	Seq.	Displays the sequential number assigned to the application tracking status record.	N/A	System displayed

Screen	Data Element	Description	Value You Key	Comments
PS-S-074	Status	Displays the provider application status code	Enter a valid status code.	"A" Approved, "D" Denied, "P" Pending, "R" Rejected
PS-S-074	Begin Date	Displays the beginning date associated with a particular application status.	N/A	System displayed
PS-S-074	End Date	The ending date associated with a particular application status.	N/A	System displayed
PS-S-074	Reason Codes	Displays the reason code for the provider subsystem	Enter valid reason code(s)	Use online help for a listing of valid reason codes.
PS-S-074	C	Displays a flag with a value of 'Y' to indicate that the application status record has a comment, or 'N' to indicate that the application status record has no comment.	N/A	N/A
PS-S-074	LP	Displays the Provider Application Tracking Letter Indicator	“Y”	If set to 'Y' a letter will go out to that provider for the application status record. Whenever a new application status record is created, the letter indicator from the previous record is set to 'N' and the new record is set to 'Y'


PS-S-074 Application Tracking Approval
VTA7 PST074
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING
STATUS
06/03/2007 20:01
Page: 001 of 001
Select Tracking ID Seq Status Begin Date End Date Reason Codes C LP
2007154002 0001 A 06/03/2007 12/31/9999 000 N Y
PROVIDER INFORMATION DISPLAYED.
Enter Update Address Letter Information Provider Info Add/Update Inquiry Restrict
EXIT


PS-S-074 Application Tracking Approval
VTA7 PST074
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING
STATUS
06/03/2007 20:02
Page: 001 of 001
Select Tracking ID Seq Status Begin Date End Date Reason Codes C LP
2007154002 0001 A 06/03/2007 12/31/9999 000 N N
DATA UPDATED.
Enter Update Address Letter Information Provider Info Add/Update Inquiry Restrict
EXIT

14.3 Error Messages (Provider Application Approval)

Screen	Error	Description	Value You Key	Comments
PS-S-074	42	ACCESS TO THE PROGRAM IS NOT AUTHORIZED	N/A	User does not have access to the screens chosen.
PS-S-074	8830	APIN INDICATOR MUST EQUAL Y OR N	Enter Y or N	N/A
PS-S-074	8840	APPLICATION NOT APPROVED: NO PROVIDER ID HAS BEEN CREATED	Retry or Exit the transaction.	N/A
PS-S-074	8824	APPLICATION TRACKING NUMBER NOT NUMERIC	Enter a valid numeric application tracking number.	N/A
PS-S-074	8841	APPLICATION TRACKING RECORD HAS NOT BEEN SELECTED, FUNCTION KEY INVALID	N/A	Information message
PS-S-074	8936	CANNOT PERFORM NPI MOVE AND LEGACY/NPI UNLINK TOGETHER. DO SEPARATELY.	Must perform tasks separately	N/A
PS-S-074	8838	CHANGE IN PROVIDER APPLICATION STATUS MUST RESULT IN CHANGE IN REASON CODE	Enter the reason code value.	N/A
PS-S-074	39	CHOOSE UPDATE TO SAVE CHANGES	Choose the update button to save the changes.	N/A
PS-S-074	3056	DATA DISPLAYED	N/A	Information message
PS-S-074	68	DATA REFRESHED	N/A	Information message
PS-S-074	27	DATA UPDATED	N/A	Information message
PS-S-074	8839	DUPLICATE REASON CODES NOT ALLOWED	Remove the duplicate reason code.	N/A
PS-S-074	116	END OF LIST	N/A	Information message

Screen	Error	Description	Value You Key	Comments
PS-S-074	4	END OF THE PAGE	N/A	Information message
PS-S-074	7	ENTER INDIVIDUAL PROVIDER NUMBER	Enter a valid individual Provider number. See the field definitions for formatting/ requirements for this field.	N/A
PS-S-074	10	ERROR OCCURRED AT RECEIVE; TRANSACTION CANCELLED	Retry the transaction, if necessary.	N/A
PS-S-074	11	ERROR OCCURRED AT SEND; TRANSACTION CANCELLED	Retry the transaction, if necessary.	N/A
PS-S-074	15	FUNCTION CHOSEN IS INVALID	Choose another function.	N/A
PS-S-074	4136	LAST PROVIDER NUMBER ASSIGNED IS NOT FOUND	Information message	Information message
PS-S-074	8832	LETTER PROCESSED INDICATOR CAN ONLY CHANGE FROM YES TO NO	Please enter value 'Y' or 'N' only.	N/A
PS-S-074	8829	LETTER PROCESSED MUST EQUAL Y OR N	Enter Y or N	N/A
PS-S-074	17	NEXT PAGE DATA IS DISPLAYED	N/A	Information message
PS-S-074	4437	NO RECORDS FOUND RETURN TO MAIN MENU TO ADD A PROVIDER APPLICATION.	N/A	Information message
PS-S-074	7066	NOTHING TO UPDATE; DATA HAS NOT CHANGED	N/A	Information message
PS-S-074	8836	ONLY ONE LONG REASON CODE ALLOWED PER STATUS ROW	Enter only one long reason code.	N/A
PS-S-074	8827	PLEASE ENTER A VALID TRACKING NUMBER	N/A	Information message
PS-S-074	20	PREVIOUS PAGE DATA IS DISPLAYED	N/A	Information message

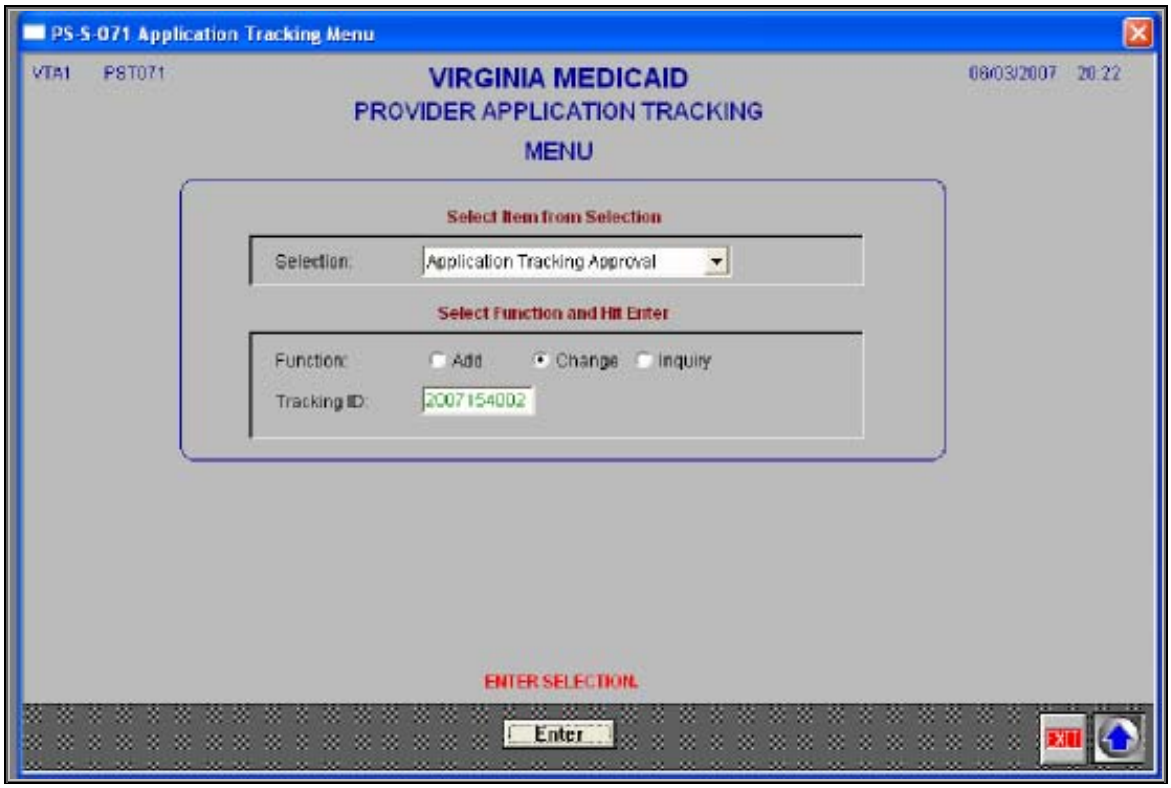
Screen	Error	Description	Value You Key	Comments
PS-S-074	4350	PROVIDER APPLICATION REASON CODE IS INVALID	N/A	Information message
PS-S-074	4135	PROVIDER APPLICATION STATUS CODE IS INVALID	N/A	Information message
PS-S-074	4098	PROVIDER INFORMATION DISPLAYED	N/A	Information message
PS-S-074	4440	PROVIDER NUMBER ALREADY EXITS	N/A	Information message
PS-S-074	4140	PROVIDER TYPE NOT FOUND	Enter a valid Provider Type.	N/A
PS-S-074	8834	REASON CODE CAN NOT CONTAIN VALUE FOR ENTERED STATUS	Correct the reason code.	N/A
PS-S-074	8916	THIS (TYPICAL PROV) APPLICATION NEEDS NPI NUMBER FOR THE APPROVAL.	Exit the screen and go back to Application tracking Add/Update screen to update Provider Id field with NPI value.	N/A
PS-S-074	29	TOP OF THE PAGE	N/A	Information message
PS-S-074	67	UNABLE TO RETURN TO PREVIOUS PROGRAM, CHOOSE THE EXIT BUTTON TO CONTINUE	Choose the EXIT button to Continue processing.	N/A
PS-S-074	43	UNIDENTIFIED SECURITY ERROR	N/A	User not authorized for the transaction.

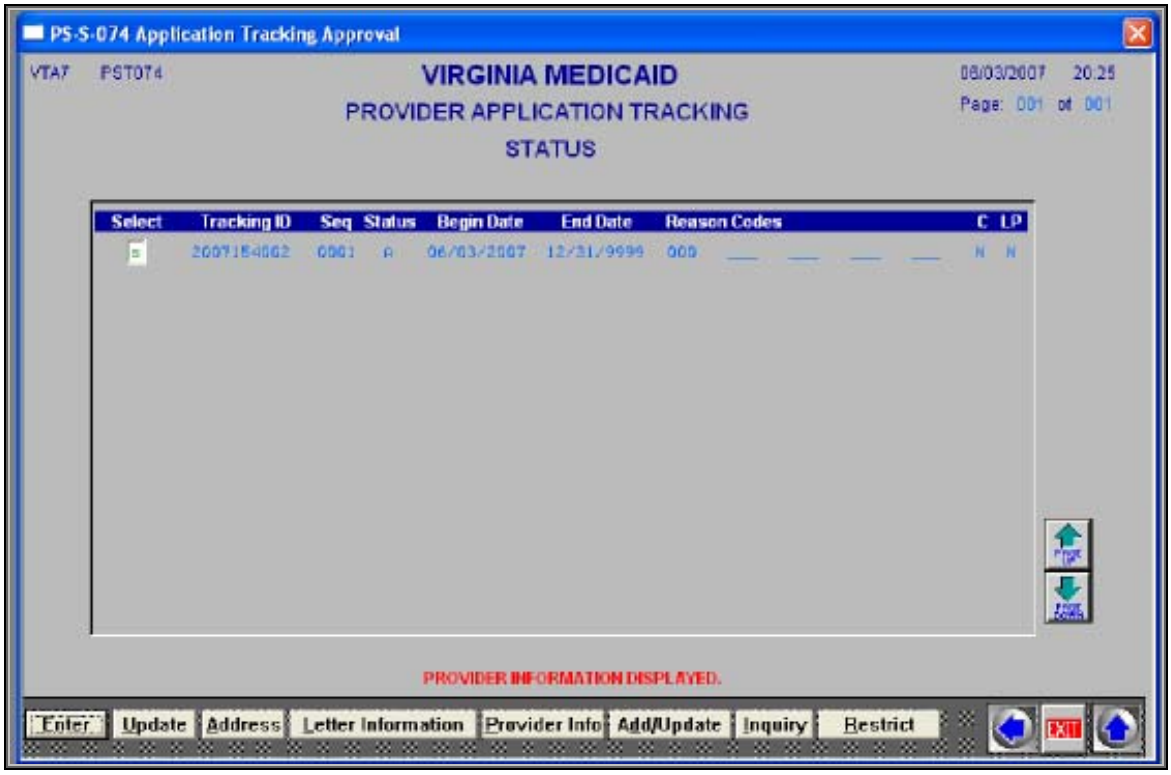
15.0 General Information (Provider Letter Information Inquiry/Update)

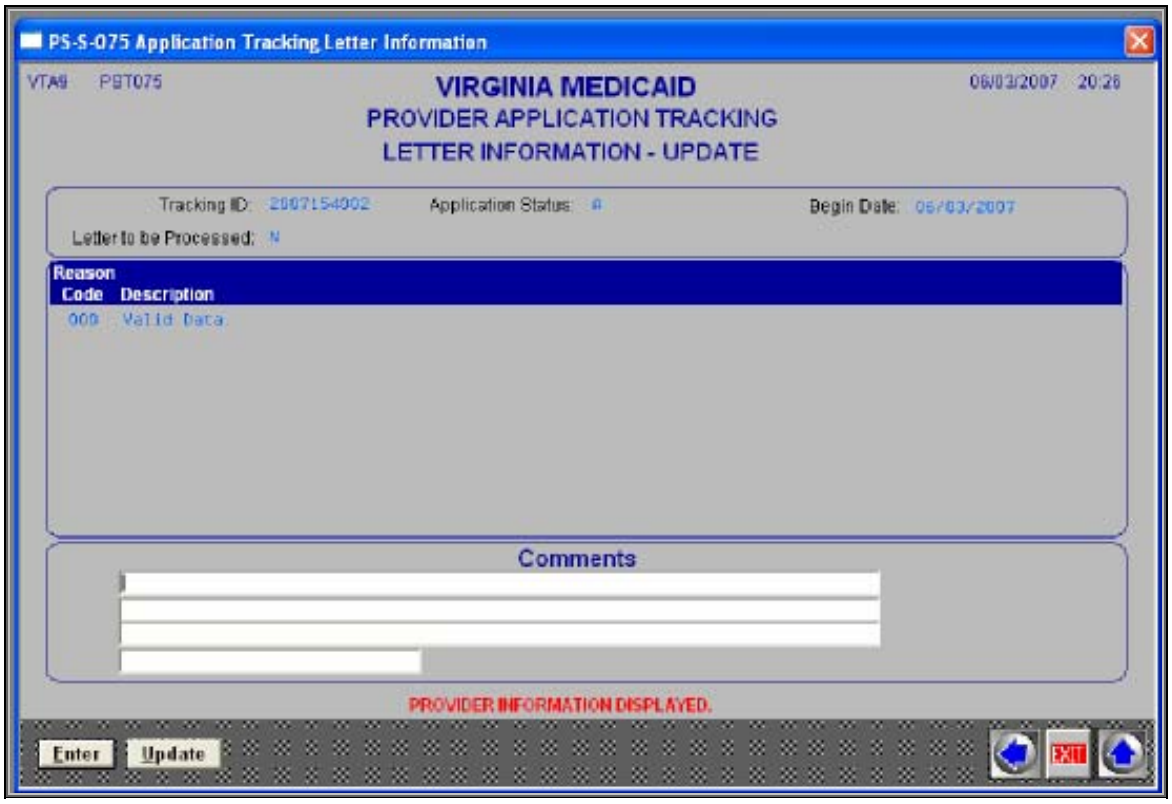
The Letter Screen is used to view the values for reason codes related to a Provider Application on the Approval screen PS-S-074. It also has the functionality of also allowing an operator to enter free form text that will serve as a comment on the Rejection/Denied Letter.

15.1 Screen Access (Provider Letter Information Inquiry/Update

1. From the **Provider Application Tracking** menu, choose the **Application Tracking Approval** selection.
2. Select the **Inquiry** or **Change** radio button in the **Function** field.
3. A tracking ID is required in the Tracking ID field. If a tracking ID is entered, it must be at least 7-bytes long, and valid.
4. Once the Application Tracking Approval Screen is Displayed, Place a '**S**' in the **Select** field for the application for which you would like to see the reason code values. This will take you to the **Letter** screen in the same function mode in which you entered the **Approval** screen. If you entered the **Application Tracking Approval** screen in Inquiry mode and would like to go to the **Letter** screen in Change mode, place a '**C**' in the **Select** field for the application for which you would like to see the reason code values. If you entered the **Application Tracking Approval** screen in Change mode and would like to go to the **Letter** screen in Inquiry mode, place an '**I**' in the **Select** field for the application for which you would like to see the reason code values.
5. Press the **Lette**r button on the **Application Tracking Approval** screen and the **Letter** screen PS-S-075 is displayed.


PS-S-071 Application Tracking Menu
VTA1 PST071
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING
MENU
08/03/2007 20:22
Select Item from Selection
Selection: Application Tracking Approval
Select Function and Hit Enter
Function: Add Change Inquiry
Tracking ID: 2007154002
ENTER SELECTION.
Enter
EXIT

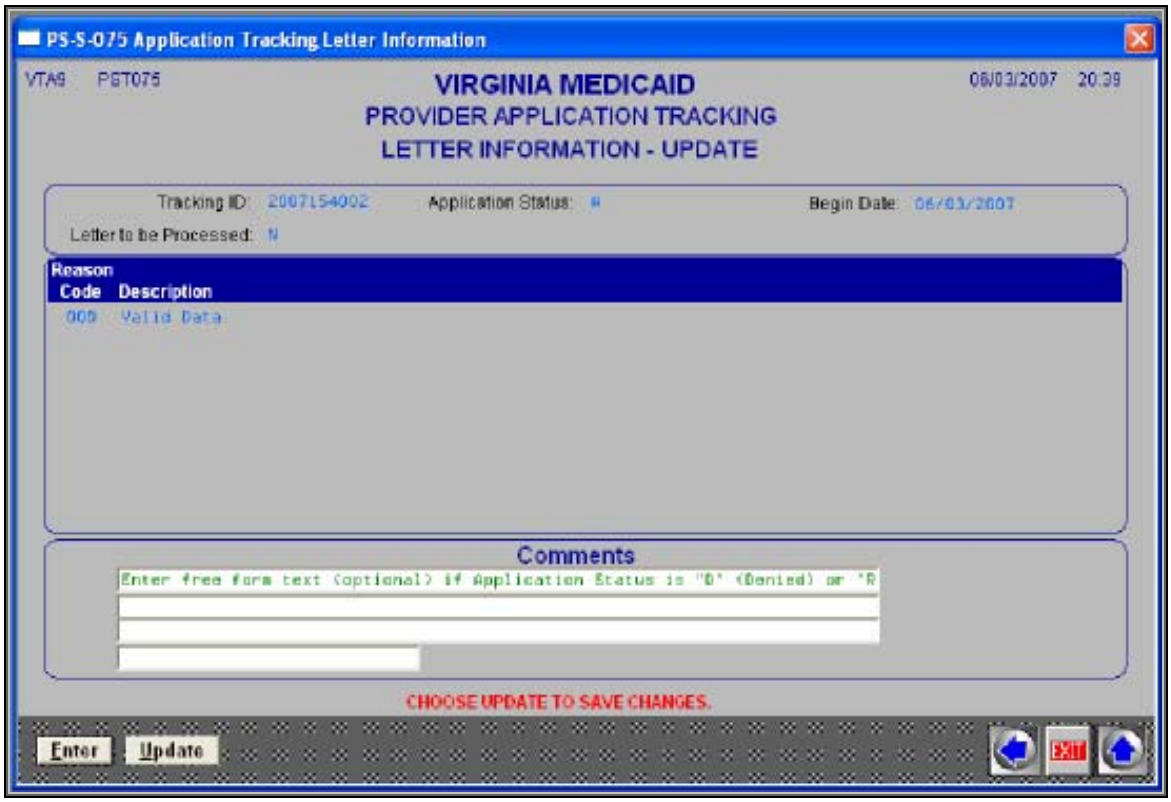

PS-S-074 Application Tracking Approval
VTA7 PST074
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING
STATUS
08/03/2007 20:25
Page: 001 of 001
Select Tracking ID Seq Status Begin Date End Date Reason Codes C LP
2007154002 0001 A 06/03/2007 12/31/9999 000 N N
PROVIDER INFORMATION DISPLAYED.
Enter Update Address Letter Information Provider Info Add/Update Inquiry Restrict
EXIT

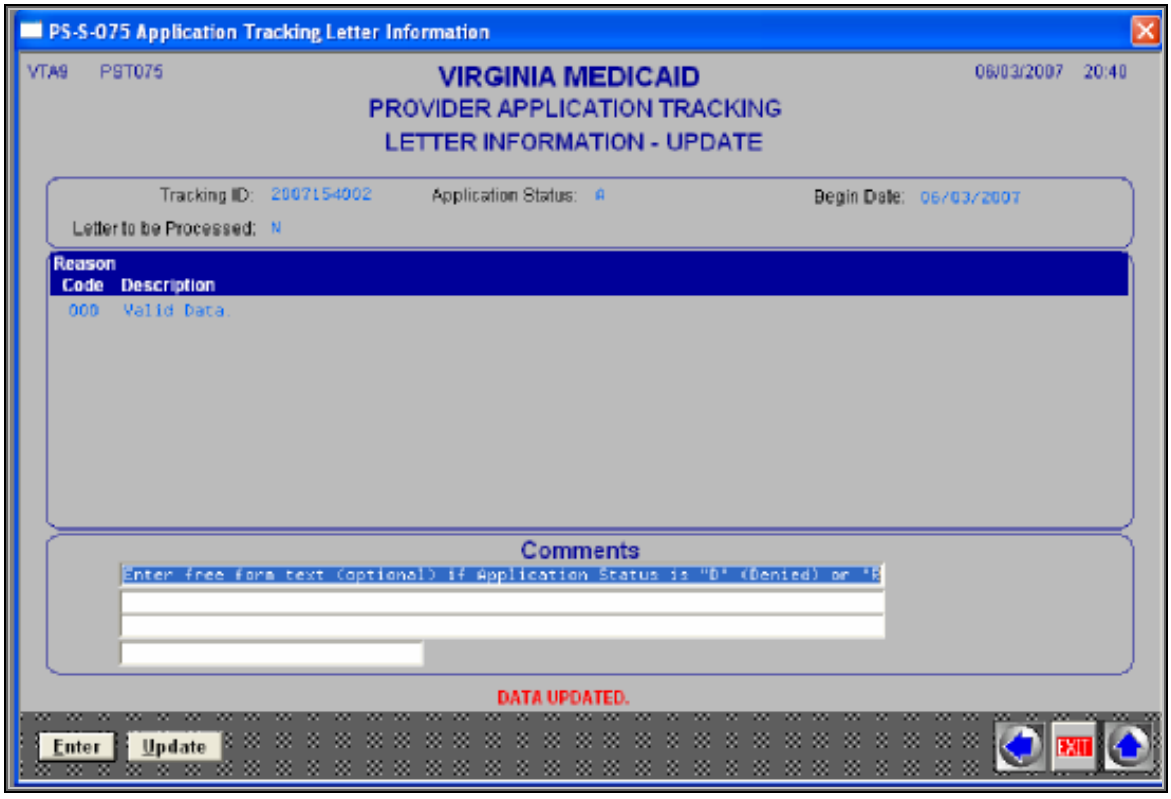


15.2 Enter Provider Data (Provider Letter Information Inquiry/Update)

Screen	Data Element	Description	Value You Key	Comments
PS-S-075	Tracking ID	Displays the new sequence number generated to make the Provider Application Tracking Number unique in the Provider Application Tracking database when a new provider application is created using the ADD transaction. If entered on a Change transaction, the Provider Application Number must equal an existing Provider Application Number.	Enter a valid Tracking ID.	N/A

Screen	Data Element	Description	Value You Key	Comments
PS-S-075	Application Status	Displays the provider application status code	N/A	System displayed
PS-S-075	Begin Date	Displays the beginning date associated with a particular application status.	N/A	System displayed
PS-S-075	Letter to be Processed	Displays the Provider Application Tracking Letter Indicator	N/A	If set to 'Y' a letter will go out to that provider for the application status record
PS-S-075	Reason Code	Displays the reason code for the provider subsystem	N/A	System displayed
PS-S-075	Description	Displays the reason code description	N/A	System displayed
PS-S-075	Comment	Displays the comments that may be entered for an application tracking status record.	Enter free form text (optional) if Application Status is “D” (Denied) or “R” (Rejected) and additional text is required.	N/A


PS-S-075 Application Tracking Letter Information
VTA9 PST075
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING
LETTER INFORMATION - UPDATE
06/03/2007 20:39
Tracking ID: 2007154002
Application Status: A
Begin Date: 06/03/2007
Letter to be Processed: N
Reason
Code Description
000 Valid Data
Comments
Enter free form text (optional) if Application Status is "D" (Denied) or "R
CHOOSE UPDATE TO SAVE CHANGES.
Enter
Update
EXIT


PS-S-075 Application Tracking Letter Information
VTA9 PST075
VIRGINIA MEDICAID
PROVIDER APPLICATION TRACKING
LETTER INFORMATION - UPDATE
06/03/2007 20:40
Tracking ID: 2007154002
Application Status: A
Begin Date: 06/03/2007
Letter to be Processed: N
Reason
Code Description
000 Valid Data
Comments
Enter free form text (optional) if Application Status is "D" (Denied) or "R
DATA UPDATED.
Enter
Update
EXIT

15.3 Error Messages (Provider Application Approval)

Screen	Error	Description	Value You Key	Comments
PS-S-075	42	ACCESS TO THE PROGRAM IS NOT AUTHORIZED	N/A	User does not have access to the screens chosen.
PS-S-075	3056	DATA DISPLAYED	N/A	Information message
PS-S-075	68	DATA REFRESHED	N/A	Information message
PS-S-075	27	DATA UPDATED	N/A	Information message
PS-S-075	15	FUNCTION CHOSEN IS INVALID	Choose another function.	N/A
PS-S-075	4437	NO RECORDS FOUND RETURN TO MAIN MENU TO ADD A PROVIDER APPLICATION.	N/A	Information message
PS-S-075	7066	NOTHING TO UPDATE; DATA HAS NOT CHANGED	N/A	Information message
PS-S-075	4098	PROVIDER INFORMATION DISPLAYED	N/A	Information message
PS-S-075	67	UNABLE TO RETURN TO PREVIOUS PROGRAM, CHOOSE THE EXIT BUTTON TO CONTINUE	Choose the EXIT button to Continue processing.	N/A
PS-S-075	43	UNIDENTIFIED SECURITY ERROR	N/A	User not authorized for the transaction.

First Health Services Corporation®
A Coventry Health Care Company

Appendix E
Detailed Enrollment Manual

Version 1.1

June 12, 2008

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HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.1	04/02/08	[redacted], Documentation Management	Formatted to new template and updated all sections.

Table of Contents

HIPAA Privacy Rules **2**
Revision History **3**
Table of Contents **4**
1.0 Detailed Enrollment Procedures per Provider Type **13**
1.1 Task Description 13
2.0 Provider Enrollment General Procedures **16**
2.1 All In-State Medicaid Providers **16**
2.1.1 Guidelines for Providers Located within 50 Miles of VA BorderB and Physically Located in VA 16
2.1.2 Guidelines for In-State Provider Begin Date 18
2.2 All Out-Of-State Medicaid Providers 20
2.2.1 Guidelines for providers not within VA or within 50 miles of VA Border 20
2.2.2 Guidelines for Out-of-State Provider Begin Date 22
3.0 Contacts **23**
4.0 Invoicing **29**
5.0 County Codes **30**
5.1 Determine County/City from Zip Code 30
5.1.1 Alphabetical Listing of County Codes and State Abbreviations 30
5.1.2 Numerical Listing of County Codes and State Abbreviations 36
6.0 Enrollment Procedures **43**
6.1 IRS Change Request 43
7.0 Detailed Enrollment Procedures – Hospital (SLH) **44**
7.1 Class Type 44
7.2 Type of Agreement: 44
7.3 Required Documents 44
7.4 Period of Enrollment 44
7.4.1 Begin Date 44
7.4.2 End Date 44
7.5 Requirements 45
7.5.1 License Verification 45
7.5.2 Previous Enrollment 45
7.5.3 Recertifications 45
7.5.4 IRS Change Request 45
8.0 Detailed Enrollment Procedures -- Hospital (State Mental) **47**
8.1 Class Type 47
8.2 Type of Agreement 47
8.3 Required Documents 47
8.4 Period of Enrollment 47
8.4.1 Begin Date 47

8.4.2 End Date 47
8.5 Requirements 48
8.5.1 License Verification 48
8.5.2 Previous Enrollment 48
8.5.3 Recertifications 48
8.5.4 IRS Change Request 49
9.0 Detailed Enrollment Procedures – Hospital (Out-of-State) 50
9.1 Class Type 50
9.2 Type of Agreement 50
9.3 Required Documents 50
9.4 Period of Enrollment 50
9.4.1 Begin Date 50
9.4.2 End Date 50
9.5 Requirements 51
9.5.1 License Verification 51
9.5.2 Previous Enrollment 51
9.5.3 Recertifications 51
9.5.4 IRS Change Request 51
Detailed Enrollment Procedures – Laboratory 53
10.1 Class Type 53
10.2 Type of Agreement 53
10.3 Required Documents 53
·10.4 Period of Enrollment 53
10.4.1 Begin Date 53
10.4.2 End Date 54
10.5 Requirements 54
10.5.1 License Verification 54
10.5.2 Previous Enrollment 54
10.5.3 Recertifications 55
10.5.4 IRS Change Request 55
10.6 Overview of Clinical Laboratory Improvement Amendment (CLIA) 56
11.0 Detailed Enrollment Procedures – Licensed Clinical Social Worker (LCSW) 58
11.1 Class Type 58
11.1.1 Specialty 58
11.2 Type of Agreement 58
11.3 Required Documents 58
11.4 Period of Enrollment 59
11.4.1 Begin Date 59
11.4.2 End Date 59
11.5 Requirements 59
11.5.1 License Verification 59
11.5.2 Previous Enrollment 60

11.5.3 Recertifications 60
11.5.4 IRS Change Request 60
12.1 Class Type 62
12.2 Type of Agreement 62
12.3 Required Documents 62
13.1 Class Type 65
13.2 Specialty 65
13.3 Type of Agreement 65
13.4 Attachments 65
13.4.1 Begin Date 65
13.4.2 End Date 66
13.5 Requirements 66
13.5.1 Required License and Z-code Assignment 68
14.0 Enrollment Procedures 70
14.1 Completion of the MAP-717 (Fee File Maintenance form) 70
14.2 Authorization to Perform Personal Assistance, Respite Care, and Nursing Services 71
14.3 Fee File Maintenance Form Sample 72
15.0 Detailed Enrollment Procedures -- Hospital (SLH) 73
15.1 Class Type 73
15.2 Specialty 73
15.3 Type of Agreement 73
15.3.1 Attachments 73
15.4 End Date 73
15.5 Requirements 74
15.6 Community Mental Retardation Services 77
16.0 Day Health and Rehabilitation Services 78
16.2 Service Definition 78
16.3 Activities 78
17.0 Case Management Services 80
17.1 Service Definition 80
17.2 Activities 80
18.0 Resolving a Zcode Inquiry 81
18.1 Procedures without Macro 82
18.2 Procedures with Macro 83
19.0 Detailed Enrollment Procedures – Nurse Practitioner (NP) 84
19.1 Class Type 84
19.2 Specialty 84
19.3 Type of Agreement 84
19.3.1 Nurse Practitioner – Required Documents 84
19.3.2 Begin Date 84
19.3.3 End Date 85
19.4 Requirements 85

19.4.1 License Verification 85
19.4.2 Previous Enrollment 86
19.4.3 Recertifications 86
19.4.4 IRS Change Request 86
20.0 Detailed Enrollment Procedures – Nursing Home Part 1 87
20.1 Class Type 87
20.2 Specialty 87
20.3 Type of Agreement 87
20.3.1 Attachments 87
20.3.2 Begin Date 87
20.3.3 End Date 88
20.4 Requirements 89
21.0 Detailed Enrollment Procedures – Nursing Home Part 2 90
21.1 Type of Agreement 90
21.1.1 Attachments 90
21.1.2 Begin Date 90
21.1.3 End Date 91
21.2 Requirements 91
22.0 Detailed Enrollment Procedures – Optician 98
22.1 Class Type 98
22.2 Type of Agreement 98
22.3 Required Documents 98
22.4 Provider Name 98
22.5 Period of Enrollment 98
22.5.1 Begin Date 98
22.5.2 End Date 99
22.6 Requirements 99
22.6.1 License Verification 99
22.6.2 Previous Enrollment 100
22.6.3 Recertifications 100
22.6.4 IRS Change Request 100
22.7 Recertification 101
23.0 Detailed Enrollment Procedures – Optometrist 105
23.1 Class Type 105
23.2 Type of Agreement 105
23.3 Required Documents 105
23.4 Period of Enrollment 105
23.4.1 Begin Date 105
23.4.2 End Date 106
23.5 Requirements 106
23.5.1 License Verification 106
23.5.2 Previous Enrollment 107

23.5.3 Recertifications 107
23.5.4 IRS Change Request 107
24.0 Detailed Enrollment Procedures – Outpatient Clinic 108
24.1 Class Type 108
24.2 Speciality 108
24.3 Type of Agreement 108
24.4 Required Documents 108
24.5 Period of Enrollment 109
24.5.1 Begin Date 109
24.5.2 End Date 109
24.6 Requirements 109
24.6.1 License Verification 109
24.6.2 Previous Enrollment 110
24.6.3 Recertifications 110
24.6.4 IRS Change Request 111
24.7 Recertification 112
25.0 Detailed Enrollment Procedures – Outpatient Rehabilitation 116
25.1 Class Type 116
25.2 Specialty 116
25.3 Type of Agreement 116
25.4 Attachments 116
25.4.1 Begin Date 116
25.4.2 End Date 116
25.3 Requirements 118
25.3.1 Required data 118
25.3.2 Optional data 118
25.3.3 License verification 118
25.3.4 Is this an add? 118
25.3.5 Is this a Re-certification? 119
26.0 Detailed Enrollment Procedures – Personal Care 120
26.1 Class Type 120
26.2 Specialty 120
26.3 Type of Agreement 120
26.3.1 Begin Date 120
26.3.2 End Date 120
27.0 Description of Personal Care Services Overview 121
28.0 Requirements Overview 124
28.1 New Enrollments 124
28.2 New Enrollments – Participation Agreements 125
28.3 Re-Enrollments 126
28.3.1 RecertificationRe-certification Requirements 126
28.3.2 Changes in Ownership 126

29.0 Detailed Enrollment Procedures – Personal Care....127
29.1 Class Type....127
29.2 Specialty....127
29.3 Type of Agreement....127
29.3.1 Attachments....127
29.3.2 Begin Date....127
29.3.3 End Date....128
29.4 Point-Of-Sale (POS)....129
30.0 Detailed Enrollment Procedures – Physician....131
30.1 Class Type....131
30.2 Type of Agreement....131
30.3 Required Documents....131
30.4 Period of Enrollment....131
30.4.1 Begin Date....131
30.4.2 End Date....132
30.5 Requirements....132
30.5.1 License Verification....132
30.5.2 Previous Enrollment....133
30.5.3 Recertifications....133
30.5.4 IRS Change Request....133
30.5.5 Recertification....134
31.0 Detailed Enrollment Procedures – Podiatrist....138
31.1 Class Type....138
31.2 Type of Agreement....138
31.3 Required Documents....138
31.4 Period of Enrollment....138
31.4.1 Begin Date....138
31.4.2 End Date....139
31.5 Requirements....139
31.5.1 License Verification....139
31.5.2 Previous Enrollment....140
31.5.3 Recertifications....140
31.5.4 IRS Change Request....140
31.5.5 Recertification....141
32.0 Detailed Enrollment Procedures – Private Duty Nursing....145
32.1 Class Type....145
32.2 Specialty....145
32.3 Type of Agreement....145
32.3.1 Attachments....145
32.3.2 Begin Date....145
32.3.3 End Date....145
32.4 Overview....146

32.5 Requirements 148
32.5.1 New Enrollments 148
32.6 New Enrollments 150
32.7 Re-Enrollments 151
33.0 Detailed Enrollment Procedures – Prosthetic/Orthotic 152
33.1 Class Type 152
33.2 Type of Agreement 152
33.3 Required Documents 152
33.4 Period of Enrollment 152
33.4.1 Begin Date 152
33.4.2 End Date 153
33.5 Requirements 153
33.5.1 License Verification 153
33.5.2 Previous Enrollment 153
33.5.3 Recertifications 153
33.5.4 IRS Change Request 153
33.5.5 Recertification 154
34.0 Detailed Enrollment Procedures – Outpatient Clinic 158
34.1 Class Type 158
34.2 Type of Agreement 158
34.3 Speciality 158
34.4 Required Documents 158
34.4.1 Begin Date 158
34.4.2 End Date 159
34.5 Requirements 159
34.5.1 License Verification 159
34.5.2 Previous Enrollment 160
34.5.3 Recertifications 160
34.5.4 IRS Change Request 160
35.0 Detailed Enrollment Procedures – Renal Clinic 162
35.1 Class Type 162
35.2 Type of Agreement 162
35.3 Required Documents 162
35.4 Period of Enrollment 162
35.4.1 Begin Date 162
35.4.2 End Date 163
35.5 Requirements 163
35.5.1 License Verification 163
35.5.2 Previous Enrollment 164
35.5.3 Recertifications 164
36.0 Detailed Enrollment Procedures – Residential Psychiatric Treatment 168
36.1 Class Type 168

36.2 Specialty....168
36.3 Type of Agreement....168
36.3.1 Attachments....168
36.3.2 Begin Date....168
36.3.3 End Date....168
36.4 Requirements....169
37.0 Detailed Enrollment Procedures – Respite Care....171
37.1 Class Type....171
37.2 Specialty....171
37.3 Type of Agreement....171
37.4 Attachments....171
37.4.1 Begin Date....171
37.4.2 End Date....171
37.5 Overview....172
37.6 New Enrollments....174
37.7 New Enrollments -- Participation Agreements....176
37.8 Re-Enrollments....176
38.0 Detailed Enrollment Procedures – Rural Health Clinic (RHC)....178
38.1 Class Type....178
38.2 Specialty....178
38.3 Type of Agreement....178
38.4 Attachments....178
38.4.1 Begin Date....178
38.4.2 End Date....178
38.5 Requirements....179
39.0 Detailed Enrollment Procedures – Ambulatory Surgical Care....183
39.1 Class Type....183
39.2 Type of Agreement....183
39.3 Attachments....183
39.3.1 Begin Date....183
39.3.2 End Date....183
39.3.3 Requirements....183
39.4 Re-Enrollments....184
40.0 Detailed Enrollment Procedures – Health Department Clinic....185
40.1 Class Type....185
40.2 Type of Agreement....185
40.3 Required Documents....185
40.4 Period of Enrollment....185
40.4.1 Begin Date....185
40.4.2 End Date....186
40.5 Requirements....186
40.5.1 License Verification:....186

40.5.2 Previous Enrollment 187
40.5.3 Recertifications 187
40.5.4 IRS Change Request 187
41.0 Detailed Enrollment Procedures – Substance Abuse Clinic 188
41.1 Class Type 188
41.2 Specialty 188
41.3 Type of Agreement 188
41.4 Attachments 188
41.4.1 Begin Date 188
41.4.2 End Date 188
41.4.3 Agreement 188
41.5 Requirements 188
42.0 Detailed Enrollment Procedures – Support Coordinator 190
42.1 Class Type 190
42.2 Specialty 190
42.3 Type of Agreement 190
42.3.1 Begin Date 190
42.3.2 End Date 190
42.4 New Enrollments 191
Part B of the application. 191
42.5 New Enrollments 192
42.5.1 Re-Enrollments 193
42.5.2 Changes in Ownership 194

1.0 Detailed Enrollment Procedures per Provider Type

1.1 Task Description

The instructions in this section are maintained exclusively by the VMAP Provider Enrollment Unit. The detailed instructions for each provider type follow,, each has its own pagination.

Type	Name
73	ACR Assessment
48	Adult Day Health Care
73	AIDS Case Management
80 83	Ambulance
049	Ambulatory Surgical Center
079	Acr Assisted Living
044	Audiologist
036	Baby Care
035	Certified Registered Nurse Midwife (CRNM)
026	Pct - Chiropractor
034	Clinical Nurse Specialist (CNS)
025	Clinical Psychologist
056	Community Service Boards
019	Comprehensive Outpatient Rehab Facility (CORF)
073	Consumer-Directed Service Facilitator/Coordinator
41	Dental Clinic
039	Dentist
062	Durable Medical Equipment
073	Elderly Case Management
082 084	(Emergency) Air Ambulance
022	Treatment Foster Care Program
051	Health Department Clinic (HDC)
059	Home Health – Private

Type	Name
058	Home Health – State
046	Hospice
085	Hospital - Out-Of-State Rehab
005	Hospital – TB
014	Hospital - In-State Rehab
001	Hospital In-State
012	Hospital - Long Stay Inpatient Mental Health
004	Hospital - Long Stay
009	Hospital - Medical Surgery - Mental Retarded
013	Hospital Med-Surg Mental Health Retardation
001, 091	Hospital - SLH
007	Hospital State Mental (Less Than Age 21)
091	Hospital, Out-Of-State
070, 098	Laboratory
076	Licensed Clinical Social Worker (LCSW)
021	Licensed Professional Counselor (LPC)
020, 051 052, 053	Medallion
056	Mental Retardation (MR) Waiver Contractor
056	M HMRSAS
23	Nurse Practitioner (NP)
015 006, 010 011, 015 016, 017 018	Nursing Home
032	Optician
031	Optometrist
020, 095	Outpatient Clinic
057	Outpatient Rehabilitation
055	Personal Care
060, 096	Pharmacy

Type	Name
020, 095	Physician
030	Podiatrist
063	Private Duty Nursing
064	Prosthetic/Orthotic
020	Psychiatrist
050	Renal Clinic
077	Residential Psychiatric
047	Respite Care
053	Rural Health Clinic
049	SLH Ambulatory Surgical Care
051	SLH Health Department Clinic
071	Substance Abuse Clinic
073	Support Coordinator

2.0 Provider Enrollment General Procedures

2.1 All In-State Medicaid Providers

Provider adds, re-certifications, changes, correspondence, W-9's, and deletes must be completed within 15 business days from the date of receipt. Nursing Homes must be completed within 10 business days from the date of receipt. Provider faxes and re-submittals, must be completed within 5 business days from the date of receipt. Medallion provider adds, re-certifications, changes, correspondence must be completed within 3 business days from the date of receipt.

2.1.1 Guidelines for Providers Located within 50 Miles of VA BorderB and Physically Located in VA

Note: Providers located within 50 miles of the border are treated as in-state providers, and are en-rolled with the appropriate in-state class type, where applicable. However, their licensure would not be verified through DHP (Department of Health Professionals). DHP maintains licensure data on physically in-state providers, and some non-resident pharmacies and durable medical equipment suppliers). For instance providers who are with Duke at 718 Rutherford Street, Durham, NC are treated as instatein state (they would not be licensed through DHP).

A few examples of cities that are not physically located in Virginia, but reside along the border, and would be enrolled with an instate provider class type (PCT): Salisbury MD, Bluefield WV, Baltimore MD, Bristol TN, Washington DC, Johnson City TN, Kingsport TN, Middlesboro KY, should be treated as in state. If you are unsure or want to verify whether a city is falls within 50 miles of the VA border you may, check the cheat-sheet located at N:\groups\vpeu\procedures\50 mile list, or the internet site of www.mapquest.com.

1. Requirements for initial enrollment and re-certification:
   - ❖ Agreement form signed by the provider.
   - ❖ Faxes are acceptable.
   - ❖ Agreements submitted on thermal paper are acceptable as long as they are legible to be scanned in PCDOCS.
   - ❖ Telephone number required (for re-certification it is not necessary)
   - ❖ Physical address cannot be a PO Box.
   - ❖ Copy of license if applicable

When following the procedures to enroll a provider, if the provider does not have the appropriate data, you must still go through all the steps to ensure theprovider is informed of ALL the missing, incorrect, etc., information.

2. Every provider whether add (initial enrollment), re-certification, or re-submittal must be verified prior to processing through the List of Excluded Individuals HCFA (Health Care Financing Administration) Internet site: http://www.os.dhhs.gov/progorg/oig/cumsan/. This step is done systematically for adds
    - ❖ If the provider is not on the list, mark in lower left hand corner on agreement form the date verified, and initials of representative, who verified that information, and proceed with processing.
    - ❖ If the provider is on the list, notify supervisor and they will interoffice provider enrollment application to the DMAS (Department of Medical Assistance) Provider Enrollment Contract Monitor.
3. Review each individual Provider Class Type in Provider Enrollment Unit Manual for license requirements. All licensure must be verified either by DHP, or licensing entity specific to PCT either via Internet sites or telephone prior to enrollment.
4. The following provider types must have their licenses verified with The Board of Medicine, Department of Health Professions of Virginia.

Type	Description
34	Certified Nurse Specialists
35	Certified Registered Nurse Midwifes
26	Chiropractor
25	Clinical Psychologists
40	Dentists
62	Durable Medical Equipment
76	Licensed Clinical Social Workers
21	Licensed Professional Counselors
23	Nurse Practitioners
31	Optometrists
60	Pharmacies
20	Physicians
30	Podiatrists
102	Licensed Marriage Family Therapist

Type	Description
103	Substance Abuse Treatment Practitioner

2.1.2 Guidelines for In-State Provider Begin Date

Initial Enrollment

- Provider requests date – give them date requested no more than one year in the past fromcurrent day (never before begin date of licensure)
- Provider does not request a day – give them first day of month prior to receipt date (never before begin date of licensure).

Retroactive Enrollment

- Give them up to one year in past fromcurrent date (never before begin date of licensure)
- If cancelled within one year, in past, retro back to end date cancelled (as long as license covers those dates)

Notes

Change of Address

1. Do not change the provider's physical location or payment location, unless change is in writing.
2. Do not change the provider's physical location or payment location for any MEDALLION or NURSING HOME (PCT 06, 10, 11, 15, 16, 17, 18, 27, and 28) providers. Give all MEDALLION and NURSING HOME to appropriate representative assigned to those PCT.
3. Address changes must be submitted in writing and signed and dated either by an office administrator, or actual provider. Provider # specific to the change MUST be referenced in order to ensure accuracy of change requested.
4. If physical location changes verify that FIPS code will remain the same by using POWERZIP. (Do not use POWERZIP for out of state locations) reference state FIPS list in provider manual.
5. If FIPS code has changed make appropriate corrections.

Service Center Codes

1. If there is already an existing service center code, you must type that one in the previous service center code field.

2. Enter the new one in the service center code field.
3. Do not change the service center effective date.
4. If there was not already a service center code on the system and
    - ❖ If this is an ADD, the effective date for the service center code would be the current date.
    - ❖ If this is a CHANGE, the effective date for the service center code would be the current date.
5. Service Center requests must be signed by provider or administrator.

2.2 All Out-Of-State Medicaid Providers

Provider adds, re-certifications, changes, correspondence, W-9's, and deletes must be completed within 15 business days from the date of receipt. Nursing Homes must be completed within 10 days from the date of receipt. Provider faxes and resubmittals, must be completed within 5 business days from the date of receipt. Medallion provider adds, re-certifications, changes, correspondence must be completed within 3 business days from the date of receipt.

When going through the procedures to enroll a provider, if the provider does not have the appropriate data, you must still go through all the steps to ensure the provider is informed of ALL the missing, incorrect, etc., information.

2.2.1 Guidelines for providers not within VA or within 50 miles of VA Border

Providers located within 50 miles of the VA border are treated as in-state providers, and are enrolled with the appropriate in-state class type, where applicable.

Salisbury MD, Bluefield WV, Baltimore MD, Bristol TN, Washington DC, Johnson City TN, Kingsport TN, Middlesboro KY, and providers who are with Duke at in Durham NC, are some examples of cities physically located outside of VA, but would be enrolled with an in-state provider class type (PCT)

If unsure, check the cheat-sheet located at n:/groups/vpeu/procedures/50 mile list or the Internet site of www.mapquest.com. Providers who are with Duke at 718 Rutherford Street, Durham, NC are treated as instatein state.

Providers who are out-of-state (not within 50 miles of VA Border) may not be processed as the normal provider class type. Refer to the specific enrollment specifications for more details. For example an in-state physician would be enrolled as PCT 20 (for instatein state), and if they are physically located outside 50 of the VA border they would be enrolled PCT 95(for out-of-state).

1. Requirements for initial enrollment and re-certification:
    - ❖ Agreement form signed by the provider.
    - ❖ Faxes are acceptable.
    - ❖ Agreements submitted on thermal paper are acceptable as long as they are legible and able to be scanned in PCDOCS.
    - ❖ Telephone number is required for add not for re-certification

- ❖ Physical address can not a PO Box Number.
- ❖ A claim or supporting documentation must be attached if the provider is located outside of the 50-mile radius from VA Border, and are a new provider.
- ❖ Claims are not necessary for provider's who are re-certifying even if they arethey are considered out of state.
- ❖ A copy of license from state or agency required for their individual Provider Class Type (PCT).

When going through the procedures to enroll a provider, if the provider does not not have the appropriate data, you must still go through all the steps to ensure the provider is informed of ALL the missing, incorrect, etc., information.

2. Every provider whether add (initial enrollment), re-certification, or re-submittal must be verified, prior to processing through the List of Excluded Individuals HCFA (Health Care Financing Administration) Internet site: http://www.os.dhhs.gov/proorg/oig/cumsan/.
    - ❖ If the provider is not on the list, mark in lower left hand corner on agreement form the date verified, and initials of representative, who verified that information, and proceed with processing.
    - ❖ If the provider is on the list, notify and interoffice provider enrollment application to the DMAS(Department of Medical Assistance) Provider Enrollment Contract Monitor.
3. Review each individual Provider Class Type for license requirements. All licensure must be verified either by DHP, or licensing entity specific to PCT either via Internet site or telephone.
4. The begin effective date for an out-of-state provider enrolling for the first time will be the first date of service of claim or supporting documentation submitted. Never before begin dateof licensure or one year in past fromcurrent date.
5. The end date would be the last date of service of claim(s) submitted. End date will never go beyond license expiration date.

Claims

1. Providers physically located in VA and providers within 50 miles of the VA border do NOT have to have a claim attached.
2. Providers not physically located in VA or within 50 miles of the VA border are required to have a claim or supporting documentation for initial enrollment.

3. Re-certifications have to have a claim if they are located outside of 50 miles of VA Border. Exceptions would be nonresident pharmacy or Durable Medical Equipment (DME) providers who hold a DHP of VA license.
4. All claims received at VMAP-PEU will be forwarded to claims unit.

2.2.2 Guidelines for Out-of-State Provider Begin Date

Initial Enrollment

- Claims or documentation are required
- If a claim or submitted documentation is within one year in the past and they have sent in licensure, or if PEU is able to verify that license corroborates with the claim give the provider the first date of service on claim begin date. Will never be before initial license begin date.
- If provider submits claims more than one year in past – approval letter – mark #5 stating the date requested as the beginning eligibility date for the above provider has been denied.
- End date would be last date of service from claim(s) submitted. Submitted end date will never go beyond license expiration date

Retroactive Enrollment

- Claims or documentation are required.
- If claim or submitted documentation is within one year in the past and they have sent in licensure, or if PEU is able to verify that license corroborates with the claim give the provider the first date of service on claim. Begin date will never be before initial license begin date.
- If provider submits claims more than one year in past – approval letter – mark #5 stating the date requested as the beginning eligibility date for the above provider has been denied.
- End date would be last date of service from claim(s) submitted. End date will never go beyond license expiration date.

3.0 Contacts

Company / Contact	Local Number	Toll-free Number	Fax Number
[redacted]	[redacted]	[redacted]	[redacted]
Address		**Reason for Contact**	
[redacted]		Cost-settled providers receive rates here.	

Company / Contact	Local Number	Toll-free Number	Fax Number
[redacted]	[redacted]	[redacted]	[redacted]
Address		**Reason for Contact**	
[redacted]		Schools, School Based Clinics	

Company / Contact	Local Number	Toll-free Number	Fax Number
[redacted]	[redacted]	N/A	N/A
Address		**Reason for Contact**	
[redacted]		OLD Claims – claims that have exceeded 1 yr.	

Company / Contact	Local Number	Toll-free Number	Fax Number
DMAS Help line-Provider	804-786-6273	800-552-8627	N/A
Address		**Reason for Contact**	
600 E. Broad St, STE 1300, Richmond, VA 23219		PROVIDER CALLS ONLY -- Billing questions, participating provider fee schedule requests, etc.	

Company / Contact	Local Number	Toll-free Number	Fax Number
DMAS-Medallion / [redacted]	[redacted]	[redacted]	N/A
Address		**Reason for Contact**	
N/A		N/A	

Company / Contact	Local Number	Toll-free Number	Fax Number
DMAS-Help Line Recipient	804-786-6145	N/A	N/A
Address		**Reason for Contact**	
600 E Broad St, STE 1300, Richmond, VA 23219		RECIPIENT CALLS ONLY!	

Company / Contact	Local Number	Toll-free Number	Fax Number
DMAS-FOIA / [redacted]	[redacted]		[redacted]
Address		**Reason for Contact**	
600 E Broad St, STE 1300, Richmond, VA 23219 [redacted] or FOIA@dmas.virginia.gov		The requests may not be verbal and MUST contain the requestor's full name, address, fax number, and nature of request. Non-participating provider fee schedule requests. Any caller who does not have a provider number. Physician lists.	

Company / Contact	Local Number	Toll-free Number	Fax Number
DMAS / [redacted]	[redacted]	[redacted]	N/A
Address		**Reason for Contact**	
N/A		Transportation	

Company / Contact	Local Number	Toll-free Number	Fax Number
DOH, Automated License Verification	804-662-7636	N/A	N/A
Address		**Reason for Contact**	
N/A		N/A	

Company / Contact	Local Number	Toll-free Number	Fax Number
DOH	804-786-3921	N/A	N/A
Address		**Reason for Contact**	
N/A		N/A	

Company / Contact	Local Number	Toll-free Number	Fax Number
DOH, Emergency Medical Services	804-371-3500	800-523-6019	N/A
Address		**Reason for Contact**	
N/A		This is where the actual EMS license certificate is issued.	

Company / Contact	Local Number	Toll-free Number	Fax Number
DOH / [redacted]	[redacted]	N/A	N/A
Address		**Reason for Contact**	
		Nursing Home C & T	

Company / Contact	Local Number	Toll-free Number	Fax Number
DOH / [redacted],	[redacted]	N/A	N/A

Outpatient Rehab.			
Address		**Reason for Contact**	
N/A		Verifications or questions.	

Company / Contact	Local Number	Toll-free Number	Fax Number
DOH / [redacted]	[redacted]	N/A	N/A
Address		**Reason for Contact**	
		Nursing Home C & T	

Company / Contact	Local Number	Toll-free Number	Fax Number
DMAS / [redacted]	[redacted]		804-264-3268
Address		**Reason for Contact**	
N/A		Provider on review.	

Company / Contact	Local Number	Toll-free Number	Fax Number
DMAS / [redacted]	[redacted]	N/A	N/A
Address		**Reason for Contact**	
N/A		This is LTC division number.	

Company / Contact	Local Number	Toll-free Number	Fax Number
DMAS – Provider Enrollment / [redacted]	[redacted]		804-786-6229
Address		**Reason for Contact**	
N/A		DMAS Provider Enrollment Contract Monitor	

Company / Contact	Local Number	Toll-free Number	Fax Number
DMAS / [redacted]	[redacted]	N/A	N/A
Address		**Reason for Contact**	
N/A		This is LTC division number.	

Company / Contact	Local Number	Toll-free Number	Fax Number
DMAS Pharmacist / [redacted]	[redacted]	N/A	N/A
Address		**Reason for Contact**	
N/A		RX-Unit Dose dispensing.	

Company / Contact	Local Number	Toll-free Number	Fax Number
HCFA / [redacted] [redacted]	[redacted] [redacted]	N/A	215-861-4176
Address		**Reason for Contact**	
[redacted] [redacted]		N/A	

Company / Contact	Local Number	Toll-free Number	Fax Number

FH-PEU /	804-270-5105	888-829-5373	804-270-7027
Address		**Reason for Contact**	
4300 Cox Rd., Glen Allen, VA 23060 P.O. Box 26803, Richmond, VA 23261-6803 Resubmits: P.O. Box 26429, Richmond, VA 23260-6429		Enrollment	

Company / Contact	Local Number	Toll-free Number	Fax Number
FH-VMAP	804-270-5105 804-968-9732 804-965-9733	888-829-5373 800-772-9996 800-884-9730	804-270-7027
Address		**Reason for Contact**	
N/A		Recipient Eligibility, ARS Web Support- http://virginia.fhsc.com or 800-241-8726	

Company / Contact	Local Number	Toll-free Number	Fax Number
EMC Billing: Tape/Disk/Dial –Up	804-273-6779 804-273-6797	888-829-5373 800-924 -	N/A
Address		**Reason for Contact**	
N/A		Electronic billing (POS, EMC[service center codes])	

Company / Contact	Local Number	Toll-free Number	Fax Number
[redacted]	[redacted]	[redacted]	N/A
Address		**Reason for Contact**	
		Switches for POS billing.	

Company / Contact	Local Number	Toll-free Number	Fax Number
[redacted]	[redacted]	[redacted]	[redacted]
Address		**Reason for Contact**	
[redacted]		Anyone requesting prior authorization of services. www.dmas.keypro.org	

Company / Contact	Local Number	Toll-free Number	Fax Number
Virginia Relav Center	804-367-2100	TDD: 800-828-1120 Voice: 800-828-1140	N/A
Address		**Reason for Contact**	
N/A		Hearing Challenged	

Company / Contact	Local Number	Toll-free Number	Fax Number

USPS (Post Office)	804-775-6140	N/A	N/A
Address		**Reason for Contact**	
		Zip Code Information	

Company / Contact	Local Number	Toll-free Number	Fax Number
[redacted]	[redacted]	N/A	N/A
Address		**Reason for Contact**	
N/A		Medicare Part B carrier provider services.	

Company / Contact	Local Number	Toll-free Number	Fax Number
VA Board of Pharmacy	804-662-9900	N/A	N/A
Address		**Reason for Contact**	
N/A		N/A	

Company / Contact	Local Number	Toll-free Number	Fax Number
DSS	804-367-5809	N/A	N/A
Address		**Reason for Contact**	
N/A		Treatment Foster Care providers needing licensure, refer here.	

Company / Contact	Local Number	Toll-free Number	Fax Number
VA Board of Opticians	804-367-8509	N/A	N/A
Address		**Reason for Contact**	
N/A		N/A	

Company / Contact	Local Number	Toll-free Number	Fax Number
[redacted]	[redacted]	N/A	N/A
Address		**Reason for Contact**	
[redacted]		Participating provider's manual requests.	

4.0 Invoicing

Invoice Type	P.O. Box #	Address/Zip Code
Dental Doral Dental	27431	Richmond, VA 23261-7431 Doral Dental USA LLC 1212 N Corporate Pkwy Mequon WI 53092
HCFA	27444	Richmond, VA 23261-7444
Lab	27446	Richmond, VA 23261-7446
Personal Care	25507	Richmond, VA 23260-5507
Transportation	27447	Richmond, VA 23261-7447
Home Health	27441	Richmond, VA 23261-7441
Pharmacy	27445	Richmond, VA 23261-7445
Nursing Home	27442	Richmond, VA 23261-7442
SLH	27647	Richmond, VA 23261-7647
UB-92	27443	Richmond, VA 23261-7442
Miscellaneous	26228	Richmond, VA 23260-6228
X-Overs/Pas	Anyone	Richmond, VA

5.0 County Codes

5.1 Determine County/City from Zip Code

1. Click on your zip code directory icon. Click on the blue part.
2. If the zip code is OUT-OF-STATEout-of-state, do not use PowerZip, as it will give you the state's actual FIPS code. Use the paper table as we want the State FIPS code, not the out-of-state county FIPS code.
3. Type the zip code and press enter.
4. The 3-digit code given on the far right of the page is the FIPS county code.
5. To look up another code, click on clear and repeat starting at Step 3.

5.1.1 Alphabetical Listing of County Codes and State Abbreviations

FIPS	City or County	State
001	Accomack (county)	
901	Alabama	AL
902	Alaska	AK
003	Albemarle (county)	
510	Alexandria (city)	
005	Alleghany (county)	
007	Amelia (county)	
009	Amherst (county)	
011	Appomattox (county)	
903	Arizona	AZ
904	Arkansas	AR
013	Arlington (county)	
015	Augusta (county)	
017	Bath (county)	
019	Bedford (county)	
515	Beford (city)	
021	Bland (county)	
023	Botetourt (county)	

FIPS	City or County	State
520	Bristol (city)	
025	Brunswick (county)	
027	Buchanan (county)	
029	Buckingham(county)	
530	Buena Vista (city)	
905	California	CA
031	Campbell (county)	
033	Caroline (county)	
035	Carroll (county)	
036	Charles City (county)	
037	Charlotte (county)	
540	Charlottesville (city)	
550	Chesapeake (city)	
041	Chesterfield (county)	
043	Clarke (county)	
560	Clifton Forge (city)	
570	Colonial Heights (city)	
906	Colorado	CO
907	Connecticut	CT
580	Covington (city)	
045	Craig (county)	
047	Culpeper (county)	
049	Cumberland (county)	
590	Danville (city)	
908	Delaware	DE
051	Dickenson (county)	
053	Dinwiddie (county)	
909	District of Columbia	DC
595	Emporia (city)	
057	Essex (county)	
600	Fairfax (city)	
059	Fairfax (county)	

FIPS	City or County	State
610	Falls Church (city)	
061	Fauquier (county)	
910	Florida	FL
063	Floyd (county)	
065	Fluvanna (county)	
620	Franklin (city)	
067	Franklin (county)	
069	Frederick (county)	
630	Fredericksburg (city)	
640	Galax (city)	
911	Georgia	GA
071	Giles (county)	
073	Gloucester (county)	
075	Goochland (county)	
077	Grayson (county)	
079	Greene (county)	
081	Greensville (county)	
965	Guam	GU
083	Halifax (county)	
650	Hampton (city)	
085	Hanover (county)	
660	Harrisonburg (city)	
912	Hawaii	HI
087	Henrico (county)	
089	Henry (county)	
091	Highland (county)	
670	Hopewell (city)	
913	Idaho	ID
914	Illinois	IL
915	Indiana	IN
916	Iowa	IA

FIPS	City or County	State
093	Isle of Wight (county)	
095	James City (county)	
917	Kansas	KS
918	Kentucky	KY
097	King and Queen (county)	
099	King George (county)	
101	King William (county)	
103	Lancaster (county)	
105	Lee (county)	
678	Lexington (city)	
107	Loudoun (county)	
109	Louisa (county)	
919	Louisiana	LA
111	Lunenburg (county)	
139	Luray (Page (county)	
680	Lynchburg (city)	
113	Madison (county)	
920	Maine	ME
683	Manassas (city)	
685	Manassas Park (city)	
690	Martinsville (city)	
921	Maryland	MD
922	Massachusetts	MA
115	Mathews (county)	
117	Mecklenburg (county)	
923	Michigan	MI
119	Middlesex (county)	
924	Minnesota	MN
925	Mississippi	MS
926	Missouri	MO
927	Montana	MT
121	Montgomery (county)	

FIPS	City or County	State
928	Nebraska	NE
125	Nelson (county)	
929	Nevada	NV
930	New Hampshire	NH
931	New Jersey	NJ
127	New Kent (county)	
932	New Mexico	NM
933	New York	NY
700	Newport News (city)	
710	Norfolk (city)	
934	North Carolina	NC
935	North Dakota	ND
131	Northampton (county)	
133	Northumberland (county)	
720	Norton (city)	
135	Nottoway (county)	
936	Ohio	OH
937	Oklahoma	OK
137	Orange (county)	
938	Oregon	OR
139	Page (county)	
141	Patrick (county)	
939	Pennsylvania	PA
730	Petersburg (city)	
143	Pittsylvania (county)	
735	Poquoson (city)	
740	Portsmouth (city)	
145	Powhatan (county)	
147	Prince Edward (county)	
149	Prince George (county)	
153	Prince William (county)	

FIPS	City or County	State
940	Puerto Rico	PR
155	Pulaski (county)	
750	Radford (city)	
157	Rappahannock (county)	
941	Rhode Island	RI
760	Richmond (city)	
159	Richmond (county)	
770	Roanoke (city)	
161	Roanoke (county)	
163	Rockbridge (county)	
165	Rockingham (county)	
167	Russell (county)	
775	Salem (city)	
964	Samoa	Samoa
169	Scott (county)	
171	Shenandoah (county)	
173	Smyth (county)	
942	South Carolina	SC
943	South Dakota	SD
175	Southampton (county)	
177	Spotsylvania (county)	
179	Stafford (county)	
790	Staunton (city)	
800	Suffolk (city)	
181	Surry (county)	
183	Sussex (county)	
185	Tazewell (county)	
944	Tennessee	TN
945	Texas	TX
963	U.S. Possessions	
946	Utah	UT
947	Vermont	VT

FIPS	City or County	State
059	Vienna (city)	
948	Virgin Islands	VI
810	Virginia Beach (city)	
187	Warren (county)	
950	Washington	WA
191	Washington (county)	
820	Waynesboro (city)	
951	West Virginia	WV
193	Westmoreland (county)	
830	Williamsburg (city)	
840	Winchester (city)	
952	Wisconsin	W I
195	Wise (county)	
953	Wyoming	WY
197	Wythe (county)	
199	York (county)	

5.1.2 Numerical Listing of County Codes and State Abbreviations

FIPS	City or County	State
001	Accomack (county)	
003	Albemarle (county)	
005	Alleghany (county)	
007	Amelia (county)	
009	Amherst (county)	
011	Appomattox (county)	
013	Arlington (county)	
015	Augusta (county)	
017	Bath (county)	
019	Bedford (county)	
021	Bland (county)	
023	Botetourt (county)	

FIPS	City or County	State
025	Brunswick (county)	
027	Buchanan (county)	
029	Buckingham(county)	
031	Campbell (county)	
033	Caroline (county)	
035	Carroll (county)	
036	Charles City (county)	
037	Charlotte (county)	
041	Chesterfield (county)	
043	Clarke (county)	
045	Craig (county)	
047	Culpeper (county)	
049	Cumberland (county)	
051	Dickenson (county)	
053	Dinwiddie (county)	
057	Essex (county)	
059	Fairfax (county)	
059	Vienna (city)	
061	Fauquier (county)	
063	Floyd (county)	
065	Fluvanna (county)	
067	Franklin (county)	
069	Frederick (county)	
071	Giles (county)	
073	Gloucester (county)	
075	Goochland (county)	
077	Grayson (county)	
079	Greene (county)	
081	Greensville (county)	
083	Halifax (county)	
085	Hanover (county)	

FIPS	City or County	State
087	Henrico (county)	
089	Henry (county)	
091	Highland (county)	
093	Isle of Wight (county)	
095	James City (county)	
097	King and Queen (county)	
099	King George (county)	
101	King William (county)	
103	Lancaster (county)	
105	Lee (county)	
107	Loudoun (county)	
109	Louisa (county)	
111	Lunenburg (county)	
113	Madison (county)	
115	Mathews (county)	
117	Mecklenburg (county)	
119	Middlesex (county)	
121	Montgomery (county)	
125	Nelson (county)	
127	New Kent (county)	
131	Northampton (county)	
133	Northumberland (county)	
135	Nottoway (county)	
137	Orange (county)	
139	Luray (Page (county)	
139	Page (county)	
141	Patrick (county)	
143	Pittsylvania (county)	
145	Powhatan (county)	
147	Prince Edward (county)	
149	Prince George (county)	

FIPS	City or County	State
153	Prince William (county)	
155	Pulaski (county)	
157	Rappahannock (county)	
159	Richmond (county)	
161	Roanoke (county)	
163	Rockbridge (county)	
165	Rockingham (county)	
167	Russell (county)	
169	Scott (county)	
171	Shenandoah (county)	
173	Smyth (county)	
175	Southampton (county)	
177	Spotsylvania (county)	
179	Stafford (county)	
181	Surry (county)	
183	Sussex (county)	
185	Tazewell (county)	
187	Warren (county)	
191	Washington (county)	
193	Westmoreland (county)	
195	Wise (county)	
197	Wythe (county)	
199	York (county)	
510	Alexandria (city)	
515	Beford (city)	
520	Bristol (city)	
530	Buena Vista (city)	
540	Charlottesville (city)	
550	Chesapeake (city)	
560	Clifton Forge (city)	
570	Colonial Heights (city)	

FIPS	City or County	State
580	Covington (city)	
590	Danville (city)	
595	Emporia (city)	
600	Fairfax (city)	
610	Falls Church (city)	
620	Franklin (city)	
630	Fredericksburg (city)	
640	Galax (city)	
650	Hampton (city)	
660	Harrisonburg (city)	
670	Hopewell (city)	
678	Lexington (city)	
680	Lynchburg (city)	
683	Manassas (city)	
685	Manassas Park (city)	
690	Martinsville (city)	
700	Newport News (city)	
710	Norfolk (city)	
720	Norton (city)	
730	Petersburg (city)	
735	Poquoson (city)	
740	Portsmouth (city)	
750	Radford (city)	
760	Richmond (city)	
770	Roanoke (city)	
775	Salem (city)	
790	Staunton (city)	
800	Suffolk (city)	
810	Virginia Beach (city)	
820	Waynesboro (city)	
830	Williamsburg (city)	

FIPS	City or County	State
840	Winchester (city)	
901	Alabama	AL
902	Alaska	AK
903	Arizona	AZ
904	Arkansas	AR
905	California	CA
906	Colorado	CO
907	Connecticut	CT
908	Delaware	DE
909	District of Columbia	DC
910	Florida	FL
911	Georgia	GA
912	Hawaii	HI
913	Idaho	ID
914	Illinois	IL
915	Indiana	IN
916	Iowa	IA
917	Kansas	KS
918	Kentucky	KY
919	Louisiana	LA
920	Maine	ME
921	Maryland	MD
922	Massachusetts	MA
923	Michigan	MI
924	Minnesota	MN
925	Mississippi	MS
926	Missouri	MO
927	Montana	MT
928	Nebraska	NE
929	Nevada	NV
930	New Hampshire	NH

FIPS	City or County	State
931	New Jersey	NJ
932	New Mexico	NM
933	New York	NY
934	North Carolina	NC
935	North Dakota	ND
936	Ohio	OH
937	Oklahoma	OK
938	Oregon	OR
939	Pennsylvania	PA
940	Puerto Rico	PR
941	Rhode Island	RI

6.0 Enrollment Procedures

- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file, make the necessary changes.

6.1 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”
- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating, ”IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms”.
- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.

7.0 Detailed Enrollment Procedures – Hospital (SLH)

HOSPITAL - SLH - PCT = 001, 091

7.1 Class Type

001 - Hospital - SLH

091 - Hospital (Out-of-State) - SLH

7.2 Type of Agreement:

SLH

7.3 Required Documents

- Provider Application - all information must be included
- The hospital must have a Medicaid Number as an Acute Care Hospital already established with VA Medicaid.
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of HCFA Certification as Acute Care Hospital or JCAHO
  - ❒ If this document is not included, RTP the packet with the message,""In order to enroll with VA Medicaid as a SLH you must submit a copy of HCFA certification".

Note: If there is a HCFA Certification on file for the Acute Care Hospital number and the provider does not include a copy of the certification with the SLH application, browse [redacted] and use the certification document for the Acute Care Hospital number.

7.4 Period of Enrollment

7.4.1 Begin Date

The begin date will be May 1st of the year prior to submission.

7.4.2 End Date

The end date can not go beyond license or the expiration date of the medicaid number.

7.5 Requirements

7.5.1 License Verification

Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

- If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing.
- If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor

7.5.2 Previous Enrollment

Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADDadds or Re-submit batch.

7.5.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, and the provider is not a Medallion provider, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file and provider is not a Medallion provider, make necessary changes.
- All MEDALLION address/telephone number changes go to the MEDALLION Representative. Place a sticky note in [redacted] as to the action taken on provider's re-enrollment.

7.5.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating "IRS number is either missing numbers, or has to many, please correct and resubmit for processing."
- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,"IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms".

- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.

8.0 Detailed Enrollment Procedures -- Hospital (State Mental)

HOSPITAL State Mental (less than age 21) – PCT 007

8.1 Class Type

007 - Hospital State Mental (less than age 21)

8.2 Type of Agreement

Hospital

8.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of Medicare Certification
- Copy of JCAHO Accreditation
- If the provider is limited to an age group not eligible for Title XVIII benefits, the
  - ❒ JCAHO Accreditation is the only certification/accreditation required.
- **Note**: A supervisor must approve all Enrollment requests from Hospitals. The Medicaid Provider number for Hospitals is their Medicare 6 digit base number. The system assigns the seventh digit.

8.4 Period of Enrollment

8.4.1 Begin Date

- If physically located in VA, Begin Date will be the Medicare Certification date if presented by the provider OR the JCAHO Accreditation Date if Medicare Certification not available.
- The begin date will never be before initial certification begin date.

8.4.2 End Date

- For HCFA There is no expiration date on Certification, therefore, the provider receives 5 years from begin date.

- Enter the JCAHO accreditation end date for provider's with this accreditation type if HCFA accreditation not available.
- If provider if Recertifying and has been cancelled, the end date will be either 5 years from the effective date if HCFA certified or the JCAHO accreditation end date. The provider may not submit the HCFA certification when recertifying. Verify that the document is archived in [redacted].
- If a provider is Recertifying and has not been cancelled, the end date will be 5 years from the original end date The provider may not submit the HCFA certification when recertifying. Verify that the document is archived in PC Docs.

8.5 Requirements

8.5.1 License Verification

Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

- If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing.
- If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor

8.5.2 Previous Enrollment

Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADD or Re-submit batch.

8.5.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file, make the necessary changes.

8.5.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”
- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,”IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms”.
- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.

9.0 Detailed Enrollment Procedures – Hospital (Out-of-State)

HOSPITAL, Out-of-State, - PCT = 091

9.1 Class Type

091 - HOSPITAL, OUT OF STATE

9.2 Type of Agreement

Hospital

9.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of Medicare Certification OR
- Copy of JCAHO Accreditation

Note: A supervisor must approve all Enrollment requests from Hospitals. The Medicaid Provider number for Hospitals is their Medicare 6 digit base number. The system assigns the seventh digit.

9.4 Period of Enrollment

9.4.1 Begin Date

- Begin Date will be the Medicare Certification date if presented by the provider OR the JCAHO Accreditation Date if Medicare Certification not available.
- Begin date will never be before initial certification begin date.

9.4.2 End Date

- For HCFA There is no expiration date on Certification, therefore, the provider receives 5 years from begin date.
- Enter the JCAHO accreditation end date for providers with this accreditation type if HCFA accreditation not available.

- If provider if Recertifying and has been cancelled, the end date will be 5 years from the effective date. The provider may not submit the HCFA certification when recertifying. Verify that the document is archived in PC Docs.
- If a provider is Recertifying and has not been cancelled, the end date will be 5 years from the original end date. The provider may not submit the HCFA certification when recertifying. Verify that the document is archived in PC Docs.

9.5 Requirements

9.5.1 License Verification

Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

- If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing.
- If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor

9.5.2 Previous Enrollment

Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADD or Re-submit batch.

9.5.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, make necessary changes
- If the provider's servicing address varies from what is already on the existing provider file, make the necessary changes.

9.5.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”

- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating," IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms".
- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to re-profile submitted information with new provider number given.

Exceptions

The following providers are allowed to be enrolled as PCT 01 even though they are out-of-state:

Provider	Provider Code
Children's Hospital (NMC)	[redacted]
Duke Univ. Medical Center	[redacted]
George Washington Univ. Hosp	[redacted]
Georgetown Univ. Hosp	[redacted]
Holston Valley Med Center	[redacted]
Indian Path Hospital	[redacted]
Johnson City Med Ctr. Hosp	[redacted]
North Carolina Baptist	[redacted]
Washington Hospital Center	[redacted]

Detailed Enrollment Procedures – Laboratory

LABORATORY - PCT = 070, 098

10.1 Class Type

070 - Laboratory

098 - Laboratory (out-of-state)

10.2 Type of Agreement

Independent Laboratory

10.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of certification
  - ❒ Medicare Certification, OR (A copy of a recent Medicare RA may be used if the certification is unavailable)
  - ❒ CLIA Certification (The name on the certificate must be a close match to the name on the Application.)
  - ❒ If the Lab does not have Medicare Certification or a CLIA Certificate, see the Supervisor for approval. Mobile Imaging Labs do not have either of these certifications. A letter must accompany the Application with an explanation of why neither of these two certifications is not required for the provider.

·10.4 Period of Enrollment

10.4.1 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date. This date may not be before the certification date.
- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date. This date may not be before the certification date.

- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past fromcurrent date. This date may not be before the certification date.
- Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past fromcurrent date. If you have any exceptions, please see supervisor.

10.4.2 End Date

- In state and out of state (within 50 miles of VA Border): The date is derived from the type of certification. If Medicare, enter a date five years in the future. If CLIA certification, enter the CLIA certification end date. If both certifications are provided, enter a date five years in the future from begin date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
  - End date will never go beyond license expiration date.

10.5 Requirements

10.5.1 License Verification

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html
  - If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing.
  - If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor.
- Licensing Requirement out-of-state - The same requirements exists as those required of in-state providers.
- If license is not legible; RTP, stating “We could not verify licensure, please submit a legible copy of license".

10.5.2 Previous Enrollment

Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADD or Re-submit batch.

10.5.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file, make necessary changes.

10.5.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”
- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,” IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms”.
- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.

10.6 Overview of Clinical Laboratory Improvement Amendment (CLIA)

Medicare implemented the Clinical Laboratory Improvement Amendment (CLIA) in 1988. This HCFA mandate was originally implemented by Virginia Medicaid on August 1, 1993.

HCFA regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total, CLIA covers approximately 158,000 laboratory entities. HCFA's Division of Outcomes and Improvement, under the Center for Medicaid and State Operations, has responsibility for implementing the CLIA Program.

Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing minimum quality standards for all laboratory testing to ensure high quality patient testing regardless of laboratory location. Statutory language defines a laboratory as any facility that performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease, or impairment of, or assessment of health. The statute requires that laboratories obtain certification, pay applicable fees and comply with regulations regarding proficiency testing, personnel, inspections, patient test management, quality control and quality assurance.

The regulations establish three categories of testing based on complexity of the testing method: waived tests, moderate complexity, including the subcategory of Provider Performed Microscopy (PPM), and high complexity. Based on the complexity of the testing performed, CLIA specifies regulations for quality control, quality assurance, patient test management, personnel, inspections and proficiency testing to assure accurate and reliable laboratory testing. The Centers for Disease Control and Prevention (CDC) has responsibility for test categorization.

HCFA is charged with the implementation and enforcement of CLIA, including approval of proficiency testing programs, accreditation programs, and State exemption applications. Laboratories must first register. After registering HCFA surveys the laboratory, upon determining compliance, HCFA issues a certificate and collects the appropriate fees. Waived and PPM laboratories apply directly for the certificate as they are not subject to routine inspections. Additionally, laboratories have the opportunity to choose an approved accreditation organization to fulfill compliance with CLIA.

CLIA has successfully improved the quality of laboratory testing in the United States. The total number of deficiencies in all laboratories has dropped by 43% from the first to the second survey, with a 3% drop in the average number of deficiencies per laboratory. HCFA's

educational approach to surveys and proficiency testing promotes cooperation with providers while ensuring minimum quality standards for laboratory tests.

11.0 Detailed Enrollment Procedures – Licensed Clinical Social Worker (LCSW)

LICENSED CLINICAL SOCIAL WORKER (LCSW) - PCT = 076

11.1 Class Type

076 - LCSW

11.1.1 Specialty

016 - DD Waiver

047 - Substance Abuse (restricted, see Substance Abuse remarks)

11.2 Type of Agreement

Participation

11.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of license
  - ❒ Providers out-of-state and not within 50 miles of VA Border - A copy of the license from the state in which the provider practices must be submitted along with claims which will be used to determine period of enrollment.
  - ❒ SUBSTANCE ABUSE SPECIALTY - Providers requesting to enroll as a Substance Abuse Provider must submit proof of one of the following licenses/certificates before receiving a specialty of 47
    - ❖ Substance Abuse Counselor certified by the Board of Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals of DHP.
    - ❖ Addictions Counselor certified by the Substance Abuse Certification Alliance of VA, OR physician credentials, by the American Society of Addictions Medicine.
    - ❖ Clinical Psychologist certified in the treatment of alcohol and other psychoactive substance abuse use disorders by the American Psychological Association.

11.4 Period of Enrollment

11.4.1 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
- Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.

11.4.2 End Date

- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.

11.5 Requirements

11.5.1 License Verification

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html
  - If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing.
  - If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor
- Licensing Requirement In-state - If the provider is an instate provider or within 50 miles of the VA Border, verify license through the Department of Health of VA Internet site: http://www.dhp.state.va.us/,
  - Licensing Requirement out-of-state - If the provider is not within 50 miles of VA border, verify licensure via telephone or individual state's Department of Health

Internet site. Most state Dept. of Health Internet Sites have a web site, www.docboard.org. Unless the provider is established as an on-going provider, copies of claim(s) necessitating enrollment must be attached.

- If license is active, proceed
- If license is not active RTP, stating “In order to enroll or re-enroll you must hold an active license through the State Board in which the practice is located". OR
- If license can not be verified, either via telephone or Internet Site, RTP, stating “In order to enroll provider must hold a valid license from the State Board in which the practice is located, please resubmit attached agreement with a current copy of license, or contact your State Board to obtain licensure.” OR
- If license is not legible, RTP, stating “ We could not verify licensure, please submit a legible copy of license".

11.5.2 Previous Enrollment

Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADDs or Re-submit batch.

11.5.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file, make necessary changes.

11.5.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”
- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,”IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms”.

- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.

12.0 Detailed Enrollment Procedures – Licensed Professional Counselor (LPC)

LICENSED PROFESSIONAL COUNSELOR (LPC) - PCT = 021

12.1 Class Type

021 - LPC

12.2 Type of Agreement

Participation

12.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of license
  - ❒ Providers out-of-state and not within 50 miles of VA Border - A copy of the license from the state in which the provider practices must be submitted along with claims which will be used to determine period of enrollment.
  - ❒ SUBSTANCE ABUSE SPECIALTY - Providers requesting to enroll as a Substance Abuse Provider must submit proof of one of the following licenses/certificates before receiving a specialty of 47
    - ❖ Substance Abuse Counselor certified by the Board of Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals of DHP.
    - ❖ Addictions Counselor certified by the Substance Abuse Certification Alliance of VA, OR physician credentials, by the American Society of Addictions Medicine.
    - ❖ Clinical Psychologist certified in the treatment of alcohol and other psychoactive substance abuse use disorders by the American Psychological Association.

- 12.4 Period of Enrollment
- 12.4.1 Begin Date
- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
- Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.
- 12.4.2 End Date
- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.
- 12.5 Requirements
- 12.5.1 License Verification
- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html
- If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing
- If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor
- Licensing Requirement In-state - If the provider is an instate provider or within 50 miles of the VA Border, verify license through the Department of Health of VA Internet site: http://www.dhp.state.va.us/,
- Licensing Requirement out-of-state - If the provider is not within 50 miles of VA border, verify licensure via telephone or individual state's Department of Health Internet site. Most state Dept. of Health Internet Sites have a web site, www.docboard.org. Unless the provider is established as an on-going provider, copies of claim(s) necessitating enrollment must be attached.

- ❖ If license is active, proceed
- ❖ If license is not active RTP, stating “In order to enroll or re-enroll you must hold an active license through the State Board in which the practice is located". OR
- ❖ If license can not be verified, either via telephone or Internet Site, RTP, stating “In order to enroll provider must hold a valid license from the State Board in which the practice is located, please resubmit attached agreement with a current copy of license, or contact your State Board to obtain licensure.” OR
- ❖ If license is not legible, RTP, stating “ We could not verify licensure, please submit a legible copy of license".
- ❖ 12.5.2 Previous Enrollment
- ❖ Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADD or Re-submit batch.
- ❖ 12.5.3 Recertifications
- ❖ If payment address varies on agreement from what is already existing on the provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- ❖ If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, make necessary changes.
- ❖ If the provider's servicing address varies from what is already on the existing provider file, make necessary changes.
- ❖ 12.5.4 IRS Change Request
- ❖ If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”
- ❖ If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,”IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms”.

- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.

- ❖ 13.0 Detailed Enrollment Procedures – (Licensed Clinical Social Worker (LCSW)

MENTAL RETARDATION (MR) WAIVER CONTRACTOR - PCT = 056

13.1 Class Type

056

13.2 Specialty

044, CSB provider

046, Non-CSB provider

016, DD Waiver providers

13.3 Type of Agreement

- Physician-directed (for clinic)
- Mental Retardation Waiver Services

13.4 Attachments

- Clinic Only: HCFA approval, will probably say Community Mental Health Center.
- Copy of license

13.4.1 Begin Date

- Date of letter from DMHMRSAS or normal rule.
- Clinic: Beginning of month prior to date of receipt. For out-of-state providers, this will be the first date of service (based on submitted documentation). In no event should it be prior to effective date of license/certification.

13.4.2 End Date

Up to a five year period.

Note: These providers get new numbers. Do NOT contact DMHMR if the provider is licensed by another entity. The physical location must be in state. See your supervisor, if it is not.

MR Waiver providers are authorized to perform certain procedures only. Their authorization comes from the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) or, the Department of Rehabilitative Services (DRS) or Department of Social Services (DSS).

This authorization takes the form of a letter from DMHMRSAS or if they are not licensed by DMHMRSAS, refer to the chart below to identify the appropriate Zcode(s).

Upon assignment of a provider's number, a Fee File Maintenance form (MAP-717) must be completed and sent to VMAP to add the provider's procedure codes to the fee file.

Note: If the procedures are not added to the fee file, the provider cannot be reimbursed.

Additionally, MR Waiver providers complete "reenrollment" participation agreements each time they are approved for new services. For re-enrollments who do not have a current authorization letter or for adds, email your lead with the provider name, number, where they are located, phone number and services requested and who is the licensing entity. Place the agreement, etc. in the pending folder.

In the subject line, place the provider's number (do not use the word number or #) then name and if space available, the licensing entity

13.5 Requirements

1. Required data
   - ❖ Provider Application
   - ❖ Address Form with a physical address in the servicing address field
   - ❖ Participation Agreement forms - 1 original.
     - – Physician-directed for Mental Health Clinics
     - – Mental Retardation Waiver Services for all others

- ❖ Signed in ink by the provider.
- ❖ Physical address CANNOT be a P.O. box number.
- ❖ A telephone number must be available.
- ❖ CLINIC only - HCFA certification as a Mental Health Clinic
- ❖ Copy of license from the licensing authority.

2. Optional data for DMHMRSAS licensed providers:
   - ❖ Copy of authorization letter from DMHMRSAS. If the provider does not send a copy of the authorization, you will have to await its arrival from DMHMRSAS.
3. Does the provider have an actual address given for the physical location?
   - ❖ If only a P.O. Box is listed, RTP with reject letter.
   - ❖ If address is given, continue.
4. Does the provider have a telephone number given either on the agreement or on any correspondence included?
   - ❖ If a telephone number is NOT given, RTP with reject letter. b) If number is given, continue.
5. Verify the provider's signature is present and in ink.
   - ❖ If signature is not present, RTP with a reject letter.
     - – An example of the letter may be found in the Appendix under letters.
   - ❖ If signature is present, look in the provider's electronic folder to review additional submitted information.
6. Is there a copy of the license from the licensing authority? See chart below for specifics.
   - ❖ If yes, continue.
   - ❖ If no, RTP indicating license required and attach the welcome provider letter (it tells the licensing requirements).

13.5.1 Required License and Z-code Assignment

Item on Agreement	Required License	Zcodes
Residential Support	DSS-Adult Care Residence	Z8551, Z8596, Z8595
	DSS-Adult Foster Care	Z8551, Z8596, Z8595
	DSS-Adult Family Care	Z8551, Z8596, Z8595
	DRS-Habilitation Provider	Z8551, Z8596, Z8595
	DM H M RSAS-Interdepartmental Regulations of Residential Facilities For Children (CORE) license.	Z8551, Z8596, Z8595
	DSS-Assisted Living Facility	Z8551, Z8596, Z8595
	DMHMRSAS	Zcodes on authorization letter
Day Support	DRS-Habilitation Provider	Z8556, Z8557, Z8560, Z8561
	DRS-Pre-Vocational Services	Z8556, Z8557, Z8560, Z8561
	DMHMRSAS	Zcodes on authorization letter
Supported Employment	DRS-Vocational	Z8597, Z8598
	DRS-Pre-Vocational	Z8597, Z8598
	DRS-Supported Employment	Z8597, Z8598
	DMHMRSAS	Zcodes on authorization letter
Therapeutic Consultation		Email lead and place in pend
Personal Assistance	CBC Personal Care	No separate enrollment, make sure specialty is 46, RTP
	DMHMRSAS	Zcodes on authorization letter
Respite Care	CBC Respite Care	No separate enrollment, make sure specialty is 46, RTP
	DSS-Foster Care Home for Children	Z9421, Z9425, Z9407
	DSS-Adult Foster Care	Z9421, Z9425, Z9407
	DMHMRSAS	Zcodes on authorization letter

Item on Agreement	Required License	Zcodes
Nursing Services	CBC Private Duty Nursing	No separate enrollment, make sure specialty is 46, RTP
	Medicaid Home Health Agency and CSBs only DMHMRSAS	Zcodes on authorization letter
	All others	RTP, not eligible
Environmental Modifications	CSBs only, DMHMRSAS	Zcodes on authorization letter
	All others	RTP, not eligible
Assistive Technology	CSBs only, DMHMRSAS	Zcodes on authorization letter
	All others	RTP, not eligible
Crisis Stabilization	DMHMRSAS	Zcodes on authorization letter

7. Is there a copy of the licensing entity's authorization letter in the electronic folder?
    - ❖ If yes, continue.
    - ❖ If no, and licensing entity is DRS OR DMHMRSAS place in the pending file and email your lead with the name, address, services requested and the phone number. Be sure and put the number and name in the subject line.
    - ❖ If no, and licensing entity is DSS; call the locality given at the bottom of the license and confirm license. If the license is expired, have them fax confirmation
8. Verify the license and/or authorization letter.
    - ❖ If the addendum has less services than the provider, you must reject the agreement with the message "Agreement must indicate ONLY the services which are authorized by DMHMRSAS.". Remember to send a blank agreement.
    - ❖ If the addendum has more services than the provider does, continue.
9. If services are authorized, complete a MAP-717 (Fee File Maintenance form) with the provider's Medicaid id number and authorized procedure codes. Refer to the detailed instructions for specific details.
10. If the provider is approved, use the DMAS stamp in the appropriate field on the agreement form.
11. Do not send the letter until you are notified the fee file has been updated.

14.0 Enrollment Procedures

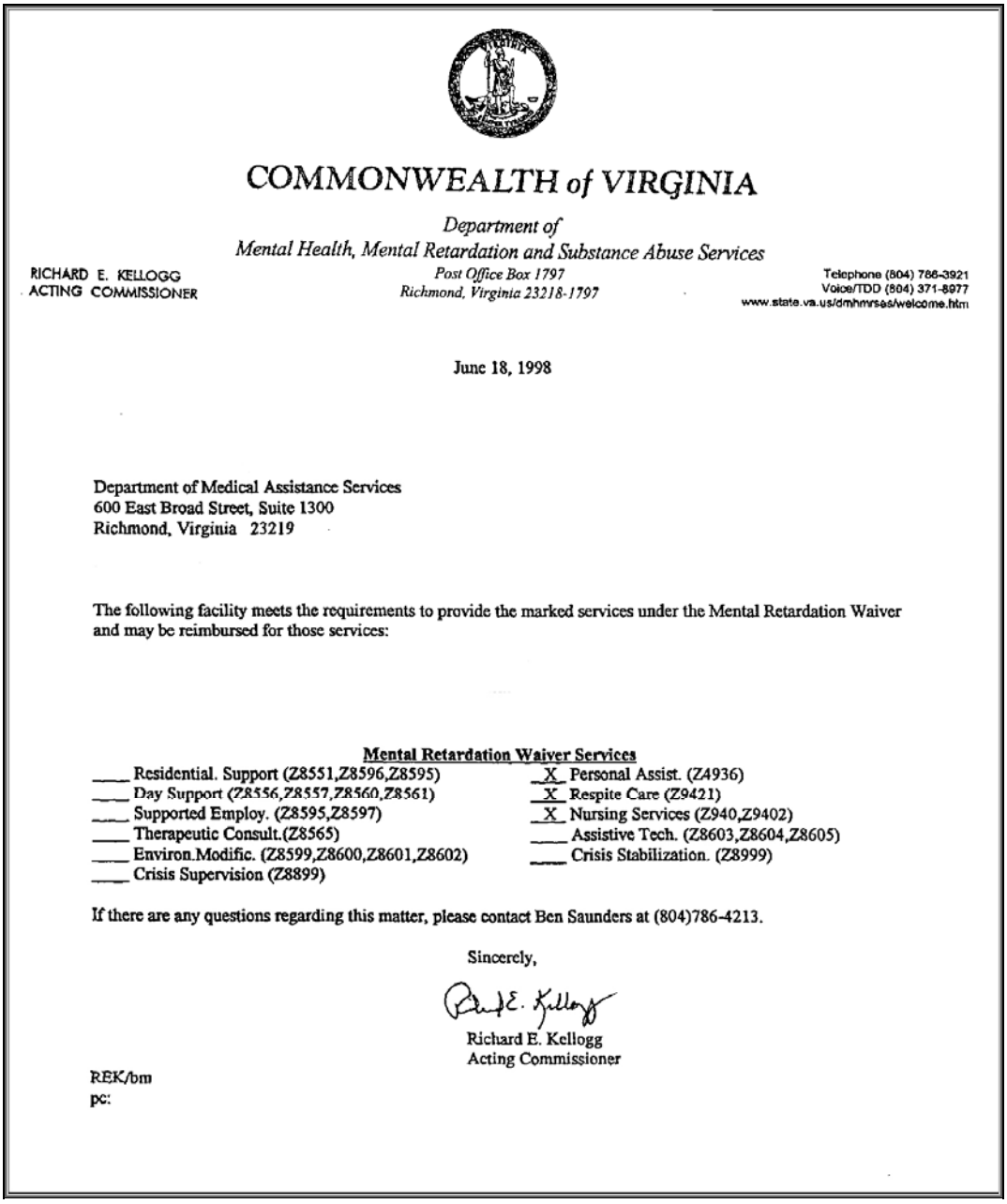
14.1 Completion of the MAP-717 (Fee File Maintenance form)

1. Procedures Without Macro
2. Navigate to N:\Groups\Procedures\Fee File.
3. Double-click on Fee File Maintenance Form.doc.
4. Tab to the form field and enter the provider number.
5. Mark whether this is an add, change, delete or inquiry.
6. Tab to the procedure code area and enter the codes in question. If there are multiple Zcodes, enter them on the left until the left column is full before going to the column on the right.
7. Tab to the initiated by prompt and enter your logon ID. 7) Print and place in the supervisor's in box.
8. Click on save as and profile as a [redacted] image with the appropriate information. 9) The supervisor will sign and fax to the QC department at VMAP.

   Note: The procedure codes billable by the provider are found on the DMHMRSAS authorization letter. Following is a sample of the MR Waivered Services authorization letter from DMHMRSAS.

14.2 Authorization to Perform Personal Assistance, Respite Care, and Nursing Services

In this example, the provider has been authorized to perform Personal Assistance, Respite Care, and Nursing Services. The billable procedure codes are Z4936, Z9421, Z9401 (DMHMRSAS erroneously has Z940 on the form, which is one digit short. They will correct that in the near future.), and Z9402.



COMMONWEALTH of VIRGINIA

Department of
Mental Health, Mental Retardation and Substance Abuse Services

RICHARD E. KELLOGG
ACTING COMMISSIONER

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.state.va.us/dmhmrsas/welcome.htm

June 18, 1998

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The following facility meets the requirements to provide the marked services under the Mental Retardation Waiver and may be reimbursed for those services:

Mental Retardation Waiver Services

____ Residential. Support (Z8551,Z8596,Z8595)
____ Day Support (Z8556,Z8557,Z8560,Z8561)
____ Supported Employ. (Z8595,Z8597)
____ Therapeutic Consult.(Z8565)
____ Environ.Modific. (Z8599,Z8600,Z8601,Z8602)
____ Crisis Supervision (Z8899)
__X__ Personal Assist. (Z4936)
__X__ Respite Care (Z9421)
__X__ Nursing Services (Z940,Z9402)
____ Assistive Tech. (Z8603,Z8604,Z8605)
____ Crisis Stabilization. (Z8999)

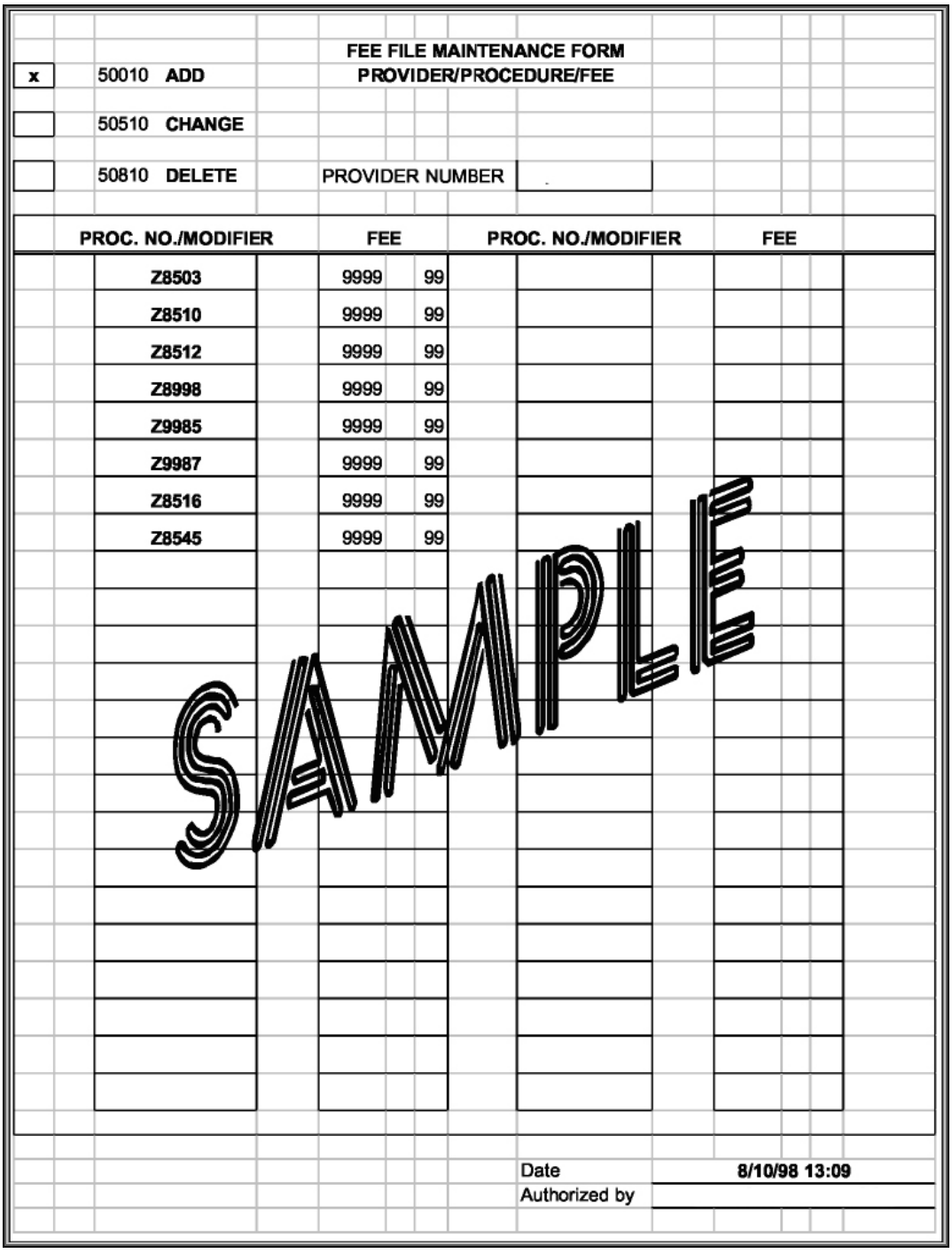
If there are any questions regarding this matter, please contact Ben Saunders at (804)786-4213.

Sincerely,

Richard E. Kellogg
Acting Commissioner

REK/bm
pc:

14.3 Fee File Maintenance Form Sample



FEE FILE MAINTENANCE FORM
PROVIDER/PROCEDURE/FEE

[x] 50010 ADD
[ ] 50510 CHANGE
[ ] 50810 DELETE

PROVIDER NUMBER

PROC. NO./MODIFIER	FEE	PROC. NO./MODIFIER	FEE
Z8503	9999 99		
Z8510	9999 99		
Z8512	9999 99		
Z8998	9999 99		
Z9985	9999 99		
Z9987	9999 99		
Z8516	9999 99		
Z8545	9999 99		

SAMPLE

Date 8/10/98 13:09
Authorized by

15.0 Detailed Enrollment Procedures -- Hospital (SLH)

MHMRSAS – PCT = 056

15.1 Class Type

056

15.2 Specialty

045 – Priv. MHSA Svcs (Private Community Mental Health Substance Abuse Services)

15.3 Type of Agreement

Mental Health & Mental Retardation &Substance Abuse Services

15.3.1 Attachments

Copy of license from DMHMRSAS (this is the one with the seal and usually says "Provider of Mental Health, Mental Retardation and Substance Abuse Services") OR copy of DSS license OR copy of DRS license. See detailed.

15.4 End Date

Non-CSB's only. The effective date is the date of signature but may never be before the licensure begin date, up to five years.

Note: Do NOT contact DMHMR if the provider is licensed by another entity. The end date and LRD will be the earliest license expiration date. Providers are authorized to perform certain procedures only. Their authorization comes from the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) or, the Department of Rehabilitative Services (DRS) or Department of Social Services (DSS).

This authorization takes the form of a letter from DMHMRSAS or if they are not licensed by DMHMRSAS, refer to the chart below to identify the appropriate Zcode(s).

Upon assignment of a provider’s number, a Fee File Maintenance form (MAP-717) must be completed and sent to VMAP to add the provider’s procedure codes to the fee file.

Note: If the procedures are not added to the fee file, the provider cannot be reimbursed.

Additionally, MHMR providers complete "new" participation agreements each time they are approved for new services.

Some of the CSBs have multiple provider ids so that they can differentiate their billing of mental health, mental retardation, and substance abuse services. Additionally, if they are providing services under the mental retardation waiver, they are issued separate provider numbers and complete the Mental Retardation Waiver Services agreement.

Note: The procedure codes billable by the provider are derived from the services which are authorized. Refer to the detailed chart.

15.5 Requirements

1. Required data
   - ❖ Provider Application
   - ❖ Address Form with a physical address in the servicing provider fields
   - ❖ Participation Agreement form - 1 original.
   - ❖ Signed in ink by the provider.
   - ❖ Physical address CANNOT be a P.O. Box number.
   - ❖ A telephone number must be available.
   - ❖ Copy of license from the licensing authority.
2. Optional data for DMHMRSAS licensed providers:
   - ❖ Copy of authorization letter from DMHMRSAS. If the provider does not send a copy of the authorization, you will have to await its arrival from DMHMRSAS.
3. Does the provider have an actual address given for the physical location?
   - ❖ If only a P.O. Box is listed, RTP with reject letter.
   - ❖ If address is given, continue.
4. Does the provider have a telephone number given either on the agreement or on any correspondence included?
   - ❖ If a telephone number is NOT given, RTP with reject letter.
   - ❖ If number is given, continue.
5. Verify the provider's signature is present and in ink.
   - ❖ If signature is not present, RTP with a reject letter.

- An example of the letter may be found in the Appendix under letters.

❖ If signature is present, look in the provider's electronic folder to review additional submitted information.

6. Is there a copy of the license from the licensing authority? See chart below for specifics.

❖ If yes, continue.

❖ If no, RTP indicating license required and attach the welcome provider letter (it tells the licensing requirements)

7. Required license and Zcode assignment.

Item on Agreement	Required License	Zcodes
MH-Intensive In-Home	DMHMRSAS - Intensive In-Home	Zcodes on authorization letter
MH-Day Treatment for Children/Adolescents	DMHMRSAS - Day Support	Zcodes on authorization letter
MH-Day Treatment Partial Hospitalization	DMHMRSAS - Day Support	Zcodes on authorization letter
MH-Psychosocial Rehabilitation	DMHMRSAS - Day Support	Zcodes on authorization letter
MH-Crisis Intervention	DMHMRSAS-Outpatient Prgm.	Zcodes on authorization letter
MH-Case Management	RTP	not eligible
MH-Intensive Community Treatment	DMHMRSAS-Outpatient Prgm.	Zcodes on authorization letter
MH-Crisis Stabilization	DMHMRSAS-Outpatient Prgm.	Zcodes on authorization letter
MH-Support Services	DMHMRSAS-Supported Living Residential or Supportive Residential	Zcodes on authorization letter
MR-Case Management	RTP	not eligible
SAS-Day Treatment for Pregnant Women	N/A	N/A
SAS-Residential Treatment for Pregnant Women	N/A	N/A

8. Is there a copy of the licensing entity's authorization letter in the electronic folder?

- If yes, continue.
- If no, and licensing entity is DRS OR DMHMRSAS place in the pending file and email your lead with the name, address, services requested and the phone number. Be sure and put the number and name in the subject line.
- If no, and licensing entity is DSS; call the locality given at the bottom of the license and confirm license. If the license is expired, have them fax confirmation

9. Verify the license and/or authorization letter.
    - If the addendum has less services than the provider, you must reject the agreement with the message "Agreement must indicate ONLY the services which are authorized by DMHMRSAS.". Remember to send a blank agreement.
    - If the addendum has more services than the provider, continue.
10. If services are authorized, complete a MAP-717 (Fee File Maintenance form) with the provider's Medicaid ID number and authorized procedure codes. Refer to the detailed instructions for specific details.
11. If the provider is approved, use the DMAS stamp in the appropriate field on the agreement form.
12. Do not send the letter until you are notified the fee file has been updated.

15.6 Community Mental Retardation Services

The following State Plan Option Mental Retardation services are covered under the Medicaid Program: Day Health and Rehabilitation Services and Case Management Services. Under the Medicaid Program, Day Health and Rehabilitation Services may be reimbursed for persons with documented need of support in appropriate areas, whereas Case Management services may be reimbursed for any person with mental retardation. All services must be pre-authorized by DMHMRSAS. Annual reauthorization by DMHMRSAS is not required. However, it is the responsibility of the Community Services Board to ensure that all consumers remain eligible and continue to need State Plan Option Mental Retardation Services.

Note: This is provided for informational purposes only. DMHMRSAS verifies the various licensure requirements of providers. DMHMRSAS' authorization letter is the only form of "licensure' documentation requested by DMAS for enrollment of these providers.

16.0 Day Health and Rehabilitation Services

16.2 Service Definition

These are individualized activities, supports, training, supervision, and transportation based on a plan of care and provided to eligible persons for two or more hours per day and scheduled multiple times per week. The objective is to enhance the consumer's functioning. Consultation to service providers, family, and friends of the consumer around the implementation of the plan of care may be included as a part of the services, provided the consumer is present.

16.3 Activities

Programs and activities must be person-centered and functional. Consumers must be involved in the planning and selection of these activities and program outcomes. Specific components of Day Health and Rehabilitation Services include the following as needed:

- Self-care and hygiene skills: training in personal appearance and cleanliness, use of medication, and dental care;
- Eating skills: training in table manners and eating in restaurants;
- Toileting skills: training in all steps of the toilet process and the practice of the skills in a variety of public/private environments;
- Task learning skills: training in eye/hand coordination tasks with varying levels of assistance by supervisors, developing alternative training strategies, and using actual, everyday sites to offer training and reinforce learning;
- Community resource utilization skills: training in time, use of the telephone, money, warning sign recognition, and personal identification such as the individual's personal address and telephone number, and use of community services, resources, and cultural opportunities;
- Environmental skills: training in punctuality, self-discipline, the care of personal belongings, respect for property, remaining on a task and adequate attendance and training in actual sites and integrated settings where the skills will be performed;
- Self-advocacy: training in problem solving and decision making;
- Behavior skills: training in the appropriate interaction and communication with supervisors and other trainees, self-control, attention to program rules and coping skills and developing/enhancing social skills in relating to the general population and peer groups; developing a sense of responsibility to one's community; decisionmaking;

- Medication management: awareness of the importance of prescribed medications, the identification of medications, the role of proper dosage and schedules, and providing assistance in medication administration including the signs of adverse effects;
- Transportation: to and from the training sites, service and support activities. Transportation time to and from the program site may be included as part of the reimbursable unit for that provider. However, transportation time exceeding 25% of the total daily time spent in the service for each individual is not covered. These restrictions apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities; and
- Opportunities to practice skills in real life settings that are integrated with the general population.

17.0 Case Management Services

17.1 Service Definition

Assists individual children, adults, and their families in accessing needed medical, psychiatric, social, educational, vocational, residential, and other supports essential to live in the community and develop their desired lifestyle.

17.2 Activities

- Assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment but does include referral for such assessment);
- Linking the individual to services and supports specified in the ISP;
- Assisting the individual directly for the purpose of developing or obtaining needed resources including crisis assistance supports;
- Coordinating services and treatment planning with other agencies and providers;
- Enhancing community integration through connections to opportunities for community access and involvement;
- Making collateral contacts with significant others to promote the implementation of the service plan and community adjustment;
- Monitoring service delivery through contacts to service providers as well as periodic site visits and home visits; and
- Education and counseling which guides the consumer in problem solving and decision making and develops a supportive relationship that promotes the service plan.
- There must be a case management contact activity, or communication relevant to the Consumer Service Plan (CSP), as defined above, during any month for which a claim for case management is submitted. Written plan development, review, or other written work is excluded.

18.0 Resolving a Zcode Inquiry

Staff

DMHMRSAS or the CSB's may call and indicate there is a problem with a particular Zcode, when they do here are the steps you need to take:

1. Follow the fee file maintenance form procedures and check inquiry.
2. Place this in the supervisor's in basket.

Supervisor

1. The Zcode fee file may be referenced utilizing TSO and SAS. The member name is Z-codes'. Change the provider number to the one being requested and run.
2. Completion of the MAP-717 (Fee File Maintenance form)

   The MAP-717 is a Word document located at:
   N:\Groups\Procedures\Forms\Fee File Maintenance Form.doc.

   You will complete this form based on the services authorized by DMHMRSAS.

   At this time, the macro is not working. LThis form has been automated via macro to prompt you for your name and the provider's 7-digit Medicaid id number. The macro then selects the first Procedure Number/Modifier field. The Procedure Number/Modifier column is formatted to key the letter "Z" of the procedure code for you; thus, you need only enter the 4-digit numeric portion of each procedure code.

The procedure codes billable by the provider are derived from the services which are authorized based upon the following chart:

Service on Agreement	Service on Addendum	Z-Codes
Intensive In-Home	Intensive In-Home Services Program License	Z8503
Day Treatment for Children/Adolescents	Day Treatment Program License	Z8997
Day Treatment Partial Hospitalization	Day Treatment Program License	Z8997
Psychosocial Rehabilitation		
Crisis Intervention		
Case Management	NEITHER is ALLOWED	
Intensive Community Treatment		
Crisis Stabilization		
Support Services		
Day Treatment for Pregnant Women		
Residential Treatment for Pregnant Women		

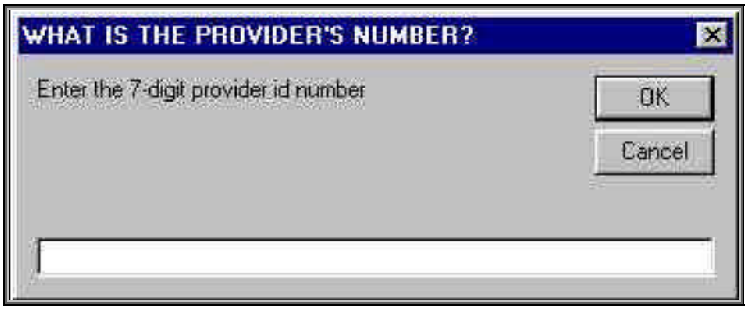
18.1 Procedures without Macro

1. Navigate to N:\Groups\Procedures\Fee File.
2. Double-click on Fee File Maintenance Form.doc.
3. Tab to the form field and enter the provider number.
4. Mark whether this is an add, change, delete or inquiry.
5. Tab to the procedure code area and enter the codes in question.
6. Tab to the initiated by prompt and enter your logon ID.
7. Print and place in the supervisor's in box.
8. Click on save as and profile as a [redacted] image with the appropriate information. 9) The supervisor will sign and fax to the QC department at VMAP.

18.2 Procedures with Macro

1. Navigate to N:\Groups\Procedures\Fee File
2. Double-click on Fee File Maintenance Form.doc
3. At the following prompt, enter your logon ID:

4. Allow the following prompt, enter the providers 7-digit ID number.



5. Key each procedure code (just the 4-digit numeric portion) and press Enter after each to proceed to the next field
6. When complete, print the form, give to [redacted] to sign and route to the QC Manager at VMAP via inner office envelope.

19.0 Detailed Enrollment Procedures – Nurse Practitioner (NP)

NURSE PRACTITIONER (NP) - PCT = 23

19.1 Class Type

023 - nurse practitioner

19.2 Specialty

- 022 - OB/GYN (Women's Health)
- 023 - Family
- 024 - Pediatric (Neo-Natal)

19.3 Type of Agreement

19.3.1 Nurse Practitioner – Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of license
  - Must have a Specialty of 02, 03, or 05. The license may have a description of the Specialty as Family, Pediatrics, OB/GYN, Women's Health or Neo-Natal.
  - Providers out-of-state and not within 50 miles of VA Border - A copy of the license from the state in which the provider practices must be submitted along with claims which will be used to determine period of enrollment. Period of Enrollment

19.3.2 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.

- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
- Begin date will never be before initial license begin date
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.

19.3.3 End Date

- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.

19.4 Requirements

19.4.1 License Verification

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html
  - ❒ If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing
  - ❒ If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor
- Licensing Requirement In-state - If the provider is an instate provider or within 50 miles of the VA Border, verify license through the Department of Health of VA Internet site: http://www.dhp.state.va.us/,
- Licensing Requirement out-of-state - If the provider is not within 50 miles of VA border, verify licensure via telephone or individual state's Department of Health Internet site. Most state Dept. of Health Internet Sites have a web site, www.docboard.org. Unless the provider is established as an on-going provider, copies of claim(s) necessitating enrollment must be attached.
- If license is active, proceed
- If license is not active RTP, stating “In order to enroll or re-enroll you must hold an active license through the State Board in which the practice is located". OR

- If license can not be verified, either via telephone or Internet Site, RTP, stating “In order to enroll provider must hold a valid license from the State Board in which the practice is located, please resubmit attached agreement with a current copy of license, or contact your State Board to obtain licensure.” OR
- If license is not legible; RTP, stating “ We could not verify licensure, please submit a legible copy of license".

19.4.2 Previous Enrollment

- Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADDs or Re-submit batch.

19.4.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file, make necessary changes.

19.4.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”
- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,”IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms”.
- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.

20.0 Detailed Enrollment Procedures – Nursing Home Part 1

- NURSING HOME - PCT = 015
- Agreement requests are referred to LTC supervisor.

20.1 Class Type

015

20.2 Specialty

Vent – 086

AIDS – 087

Complex – 089

Rehab – 092

20.3 Type of Agreement

Specialized Care

20.3.1 Attachments

- Must already be enrolled as a PCT 10
- LTC approval letter
- Rates from [redacted]

20.3.2 Begin Date

LTC effective date.

20.3.3 End Date

Notes: SNF = Skilled Nursing Facility – Medicare NF = Nursing Facility - Medicaid 49-5xxxx = medicare/medicaid 49-6xxxx = medicaid only

Tax ID Number Changes: It is the standard rule in enrollment to issue new provider id numbers when a change in tax id occurs.

This is not the case with those provider types whose Medicare id numbers are used as the base Medicaid number.

The only time Enrollment issues a new Medicaid id number for these facilities is when the Medicare id number changes.

20.4 Requirements

1. Required data
    - ❖ Application - all fields must be completed
    - ❖ Address form with a physical Address in the Servicing Address field
    - ❖ Participation Agreement -
    - ❖ Copy of HCFA certification (Medicare/Medicaid Certification and Transmittal [C & T]).
2. Is there a copy of the submitted HCFA C & T in the electronic folder?
    - ❖ If yes, continue.
    - ❖ If no, RTP with reject letter.
3. Determine the Class Type.
    - ❖ To determine the class type you will need to compare the following fields on the C & T.
        - – Box 7
        - – Box 14

Box 7	Box 14	Class Type	Description	Prov # Range
03	SNF/NF;NF /NF	006	SNF, Mental Health	49-5
02	SNF/NF (18/19)	010	SNF, non Mental Health	49-5
		011	SNF, Mentally Retarded	
03	SNF/NF (18/19) & NF (19)	015	ICF	49-5
03	N F (19)	015	ICF	49-6
10	IMR	015	ICF	49-6
11	IMR	015	ICF	49-6
10	ICF	016	ICF, Mental Health	49-6
10	ICF	017	ICF, Mentally Retarded State Owned	49-6
11	IMR	018	ICF, Mentally Retarded Community Owned	49-6

21.0 Detailed Enrollment Procedures – Nursing Home Part 2

NURSING HOME PCT = 006, 010, 011, 015, 016, 017, 018

- Provider number range 49-5xxx. New providers ONLY. This set of instructions are ONLY for providers who do not have any medicaid number.

Class Type Code	Description
006	SNF, Mental Health
010	SNF, non Mental Health
011	SNF, Mentally Retarded
015	ICF
016	ICF, Mental Health
017	ICF, Mentally Retarded State Owned
018	ICF, Mentally Retarded Community Owned

21.1 Type of Agreement

Nursing Home

21.1.1 Attachments

HCFA certification (C&T)

21.1.2 Begin Date

- HCFA approved date
- Clifton Gunderson rates

21.1.3 End Date

Five years

Notes: SNF = Skilled Nursing Facility - Medicare NF = Nursing Facility – Medicaid 49-5xxxx = medicare/medicaid 49-6xxxx = medicaid only

Tax ID Number Changes: It is the standard rule in Enrollment to issue new provider id numbers when a change in tax id occurs.

This is not the case with those provider types whose Medicare id numbers are used as the base Medicaid number.

The only time Enrollment issues a new Medicaid id number for these facilities is when the Medicare id number changes.

21.2 Requirements

1. Required data
   - ❖ Application with all fields completed
   - ❖ Address Form. This must have a Servicing Address
   - ❖ Participation Agreement form.
   - ❖ Copy of HCFA certification (Medicare/Medicaid Certification and Transmittal [C & T]).
     - – Faxes are not acceptable.
2. Is there a copy of the submitted HCFA C & T in the electronic folder?
   - ❖ If yes, continue.
   - ❖ If no, RTP with reject letter.
3. Determine the Class Type.
   - ❖ To determine the class type you will need to compare the following fields on the C & T.
     - – Box 7
     - – Box 14

Box 7	Box 14	Class Type	Description	Prov # Range
03	SNF/NF (18/19) & NF (19)	006	SNF, Mental Health	49-5
02	SNF/NF (18/19)	010	SNF, non Mental Health	49-5
		011	SNF, Mentally Retarded	
03	SNF/NF (18/19) & NF (19)	015	ICF	49-5
03	N F (19)	015	ICF	49-6
10	IMR	015	ICF	49-6
11	IMR	015	ICF	49-6
10	ICF	016	ICF, Mental Health	49-6

4. HCFA Certification and Transmittal

Field #	Name	Values	First Health's Use
1	Medicare/Medicaid #	The 6 digit Medicare #	Use this as the provider #.
2	State vendor or Medicaid #	The 7 digit Medicaid #	Write the # in.
3	Name and address.		Should match the agreement.
4	Type of action.	1 = initial 2 = recertification 3 = termination 4 = CHOW 5 = validation 6 = complaint 7 = on-site visit 8 = termination of ICF beds 9 = other	
5	Ownership change date.		
6	Survey date.		
7	Provider category.	01 = hospital 02 = SNF/ICF - dual 03 = SNF/ICF - distinct 04 = SNF 05 = home health 06 = lab 07 = x-ray 08 = OPT/SP 09 = ESRD 10 = ICF 11 = IMR 12 = RHC 13 = PTIP 14 = CORF 15 = ASC 16 = hospice	
8	Accreditation status	0 = unaccredited 1 = JCAH 2 = AOA 3 = Other	
9	Fiscal year end date		

Field #	Name	Values	First Health's Use
10	Facility certified		
11	LTC certification period		
12	Total facility beds		
13	Total certified beds		
14	LTC certified bed breakdown	018 - SNF 018/019 - SNF 019 - SNF ICF IMR SNF/ICF dual certified	
15	Facility meets		
16	Survey remarks		
17	Surveyor signature		
18	Survey agency approval		
19	Eligibility determination	1 = eligible 2 = not eligible	
20	Compliance with Civil Rights Act		
21			
22	Original participation date		
23	LTC agreement begin date		
24	LTC agreement end date		
25	LTC extension date		
25A	Suspension of admissions		
25B	Rescind suspension date		

Field #	Name	Values	First Health's Use
26	Termination action	Voluntary 1 = merger, closure 2 = dissatisfaction with re-imbursement 3 = risk of involuntary termination 4 = other reason	
		Involuntary 5 = fail to meet health/safety 6 = fail to meet agreement Other 7 = Provider status change	
27	Alternative sanctions		
28	Termination date		
29	Intermediary/carrier #		
30	Remarks		
31	Receipt of HCFA-1539		
32	Determination of approval date		
31	Receipt of HCFA-1539		
32	Determination of approval date		

5. Determine the Class type.

   - ❖ You will get C & T (provider merging over to skilled (SNF/NF Show in Block 1 Type of Action and Block 14 show 018/019- SNF/NF; and 019 NH
     - – On CICS, you will look up the provider name.
     - – Get printout of there 49-6xxx provider number.
     - – Mail certification letter and blank agreements to provider for their new skilled provider number.

- Sent copy of letter to Clifton Gunderson notify them for new provider number for skilled.
- Hold package in pending file until you Received
  - Agreements
  - HCFA showing 49-5xxx 2 (effective date) for skilled number.
- When you have received all above providers, is ready for new 49-5-xxxx 1 and 2 pages and printout if the rates, PF10 netcep PF11 pirs rate
- Go to V01A key in class type 10 your screen add will appear.
- Type in the info (from Agreements, rates) under old number 49-6...
- When completed, provider added new 49-5xxxx.

❖ You will complete a Nursing Home ownership change form- (Program-Rme0700B)

- See attached form (sample)
- Put in todays date, your name
- On line 1 put new provider number 49-5xxxx, old number 49-6xxx

❖ Admission date 01-28-99 (effective date here) exception indicator

- Fax into FHS- [redacted]
- Indicate that you want a copy of the program audit trail when completed sent to your attn: YOUR NAME.

❖ Also send (fax) a letter to the (billing dept) of that nursing home (see sample) this letter indicate that they can not bill under either provider number until you have completed the run (QC) it normally takes about 2 days when the run is completed from QC.

6. When you have received the audit trail (recipient transfer over to new number 49-5xxxx) they are ready to use the new number49-5xxxx you can call them let them know that they can bill under new number. 49-5xxxx (NOTE: PLEASE document this that you have inform them of the new number 49-5xxxx.)

   Note: Except for the recipient that have not gone over (from list audit trail run you received for QC.

   Note: Move the recipients as long as the OLD provider number was canceled within the last year.

Note: Recipients not gone over yet you can fax this list to [redacted] & DMAS she will then move the remaining recipient over to the new number 49-5xxxx.

- ❖ Mail copy of Agreement by [redacted] to provider and send copy to Clifton Gunderson (Approval Letter).

22.0 Detailed Enrollment Procedures – Optician

OPTICIAN - PCT = 032

OPTICIAN CLINIC - PCT = 032

22.1 Class Type

032 - Optician, Optician Clinic

22.2 Type of Agreement

Participation

22.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of license
  - License issued by the Board of Opticians must be submitted. Optician Clinics must submit a copy of the license from the Clinic site.
  - Providers out-of-state and not within 50 miles of VA Border - A copy of the license must be submitted along with claims which will be used to determine period of enrollment.

22.4 Provider Name

- Optician - Individuals name
- Optician Clinic - Clinic business name

22.5 Period of Enrollment

22.5.1 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.

- If physically located outside of VA, and are NOT within 50 miles of VA BorderBegin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
- Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.

22.5.2 End Date

- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.

22.6 Requirements

22.6.1 License Verification

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html
  If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing.
  If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor
- Licensing Requirement In-state - If the provider is an instate provider or within 50 miles of the VA Border, verify the license through the Department of Professional and Occupational Regulation: http://www.dpor.state.va.us/regulantlookup/SELECTION_INPUT.CFM
  Licensing Requirement out-of-state - If the provider is not within 50 miles of VA border, verify licensure via telephone or individual state's Licensing Board Internet site. Most states have a web site, www.docboard.org. Unless the provider is established as an on-going provider, copies of claim(s) necessitating enrollment must be attached.
- If license is active, proceed
- If license is not active RTP, stating “In order to enroll or re-enroll you must hold an active license through the State Board in which the practice is located". OR
- If license can not be verified, either via telephone or Internet Site, RTP, stating “In order to enroll provider must hold a valid license from the State Board in which the practice is

located, please resubmit attached agreement with a current copy of license, or contact your State Board to obtain licensure." OR

- If license is not legible, RTP, stating " We could not verify licensure, please submit a legible copy of license".

22.6.2 Previous Enrollment

Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADD or Re-submit batch.

22.6.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file, make necessary changes.

22.6.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating "IRS number is either missing numbers, or has to many, please correct and resubmit for processing."
- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,"IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms".
- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.
- If license has been verified, through DHP, or individual states licensing board, and provider is licensed into the future and not sanctioned by HCFA/CMS, you may begin to enter the agreement.
- If provider approved, create response letter for provider, and save onto provider's file in [redacted]. Remember to PROFILE provider number on submitted information in [redacted],

and correct Provider name if applicable. Use the DMAS stamp in the appropriate field on agreement form.

- If provider is rejected make sure to indicate ALL missing information on reply letter, verify grammar, and spelling prior to saving letter in [redacted] and mailing out to provider.
  - ❒ If PEU or PEU representative is unable to process a physician agreement, and has given it to another party to handle, please put a sticky note in [redacted] on agreement form as to what action was taken on that particular provider, and their enrollment.

22.7 Recertification

Make sure “Indefinite” agreement form filled out if it isnot reject-use Reject limited letter and send back blank indefinite agreements to provider.

If L/I indicator is “I”, agreement form is not required. If they have filled out an Indefinite agreement, and already have an “I” in indicator field on provider file, PEU will still verify and make any necessary corrections to provider file.

1. Verify the provider's signature is present on agreement form
   - ❖ If it is not RTP by checking box #3 on Reply letter indicating, “An original signature and date are required on agreement.”
   - ❖ If signature is present, proceed
2. Did the provider submit address information on agreement form?
   - ❖ If only a P.O. Box is listed on agreement form submitted for either physical or payment location, see if there is a non P.O. Box address already in system. If there is one in system, proceed and place the P.O. Box from agreement form in Payment address field on provider file in CICS and move non P.O. Box address into Alternate address field on providers file. If address in CICS on providers file, and on agreement form are a P.O. Box only RTP. State on the reject letter. “In order to reenroll with VA Medicaid provider must have a servicing location that is not a P.O. Box, please resubmit attached agreement with address other than P.O. Box for servicing location.”
   - ❖ If only a payment location was given and it is not a P.O. Box, that is okay, more than likely it is the payment and servicing location, proceed
3. If payment address varies on agreement from what is already existing on provider file and they have a separate physical address, make necessary changes to payment address on provider file.
4. If payment/servicing location are the same and the address varies on the agreement from what is already on existing provider file, and the provider is not a Medallion provider,

make necessary changes. Make sure that the FIPS code remains the same, if not change the FIPS code in provider file.

5. If the providers physical address varies on agreement from what is already on existing provider file and provider is not a Medallion provider, make necessary changes. Make sure that the FIPS code remains the same, if not change FIPS code on provider file.
6. If the provider's Phone number varies on agreement from what is already on existing provider file, make necessary changes. Only exception would be if provider were Medallion.
7. All Medallion address/telephone number changes go to Medallion representative. Make sure to place sticky notes in [redacted] as to action taken on providers re-enrollment.

    - ❖ Provider's specialty filled out on agreement form
        - – YES OR NO it is not necessary for provider to supply specialty information on a re-enrollment agreement form, proceed
        - – If specialty on agreement varies from specialty indicated on existing provider file, please see lead supervisor for special handling instructions, to determine if a new provider # is necessary.
    - ❖ IRS Identification Number written on agreement form
        - – YES, proceed
        - – If any part of IRS number is missing, or has to many numbers required of an IRS number, RTP, stating "IRS number on agreement form is either missing numbers, or has to many, please correct and resubmit for processing."
        - – If IRS number on agreement form varies from IRS number already on existing provider file RTP checking of box #1 on Reply Letter. Stating,"IRS identification number has changed, you will need to notify us in writing, to cancel this provider number. And request a new provider number by completing the enclosed blank agreement forms, or mark through provider number written on agreement form and checkbox in upper right hand corner on agreement form, requesting new number."
        - – If IRS number on agreement form varies from IRS number already on existing provider file, but they have checked box in upper right hand corner of agreement form requesting new number, cross out the provider number written on agreement form, and proceed to process a new number for provider. After new number is given, PEU representative will have to re-profile submitted information with new provider number given.

- ❖ Does the provider have a telephone number given either on the agreement or on correspondence included?
  - – YES, proceed
  - – NO, not necessary for re-certification, as long as there is a phone number on the provider file. If there is not a phone number on provider file, review correspondence attached to see if telephone number was made available and enter phone number in provider file. If no telephone number exists, return to provider, requesting phone number.
- ❖ If license has been verified through DHP, or individual states licensing board, and provider is licensed into the future and not sanctioned by HCFA/CMS, you may begin to enter the agreement.
- ❖ If Medicare Crossover and Vendor Number information has been supplied by provider, review Medicare Crossover information in manual to verify whether automatic crossover applies to provider, and proceed to process for Medicare Crossover, if applicable.
- ❖ If provider is approved, create response letter for provider and PROFILE provider number on submitted information in [redacted]. Use the DMAS stamp in the appropriate field on the agreement form.
- ❖ If provider is rejected, make sure to indicate ALL missing information is requested from provider. Also check word usage, and spelling prior to returning to provider and saving in [redacted].
- ❖ If PEU or PEU representative is unable to process a physician agreement, and has given it to another party to handle, please put a sticky note in [redacted] on agreement form as to what action was taken on that particular provider, and their re-enrollment.

- The information you enter in these fields is derived largely from the participation agreement.
- The provider's name is taken from the Name line.
- The provider's specialty is derived from information supplied by the provider at the bottom of the participation agreement.
- The provider's IRS number is found below the City/County information on the agreement form
- The eligibility begin date is derived either from the date of signature on the agreement or from the date requested by the provider or claim(s) submitted not going beyond 1 yr. in the past.
- The eligibility end date is not directly derived from the participation agreement. If the provider is requesting a specifically limited period of time for his enrollment, he may have

entered it on the agreement; however, the end date is based on expiration date of licensure or if provider not within 50 miles of VA border claim(s) submitted.

- Once all required information has been entered on page 1 of the ADD screen, you can proceed to page two. Page 2 of the file contains the provider's payment and alternate addresses, as well as the provider's phone number. Required elements on page 2 are as follows:
    - ❖ Pre-authorization notices are mailed to the alternate address. Additionally, there are times when a programmer specifically extracts the alternate address as the target for a mailing.
- The provider's address information is found on the participation agreement.
- If the provider supplies only one address, then that address is keyed into the Payment Address fields. If the provider's payment address is a Post Office box or drawer, the provider must have a physical (alternate) address.
    - ❒ If you accidentally key information (even a space) into an Alternate Address field when there is no alternate address to enter, you will have to use the End key to clear each of the alternate address fields. Otherwise, the system assumes that there are additional data elements to be added to these fields to complete the address, and you will not be able to complete processing unless the fields are cleared or an alternate address is added.
        - ❖ Do not use the spacebar to clear fields.

23.0 Detailed Enrollment Procedures – Optometrist

Optometrist - PCT = 031

23.1 Class Type

031 - Optometrist

23.2 Type of Agreement

Participation

23.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of DHP license
  - ❒ Providers out-of-state and not within 50 miles of VA Border - A copy of the license from the state in which the provider practices must be submitted along with claims which will be used to determine period of enrollment.

23.4 Period of Enrollment

23.4.1 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
  - ❒ Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.

23.4.2 End Date

- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.

23.5 Requirements

23.5.1 License Verification

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

  If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing

  If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor

- Licensing Requirement In-state - If the provider is an instate provider or within 50 miles of the VA Border, verify license through the Department of Health of VA Internet site: http://www.dhp.state.va.us/,

  Licensing Requirement out-of-state - If the provider is not within 50 miles of VA border, verify licensure via telephone or individual state's Department of Health Internet site. Most state Dept. of Health Internet Sites have a web site, www.docboard.org. Unless the provider is established as an on-going provider, copies of claim(s) necessitating enrollment must be attached.

- If license is active, proceed
- If license is not active RTP, stating “In order to enroll or re-enroll you must hold an active license through the State Board in which the practice is located". OR
- If license can not be verified, either via telephone or Internet Site, RTP, stating “In order to enroll provider must hold a valid license from the State Board in which the practice is located, please resubmit attached agreement with a current copy of license, or contact your State Board to obtain licensure.” OR
- If license is not legible; RTP, stating “ We could not verify licensure, please submit a legible copy of license".

23.5.2 Previous Enrollment

- Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADD or Re-submit batch.

23.5.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, and the provider is not a Medallion provider, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file and provider is not a Medallion provider, make necessary changes.
- All Medallion address/telephone number changes go to the Medallion representative. The representative places a sticky not in [redacted] as to the action taken on providers re-enrollment.

23.5.4 IRS Change Request

- If any part of the IRS number is missing, or has more numbers than an IRS number, RTP, stating, “The IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”
- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,”The IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms.”
- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After a new number is given, the PEU representative will have to re-profile submitted information with new provider number given.

24.0 Detailed Enrollment Procedures – Outpatient Clinic

OUTPATIENT - PCT = 020, 095

Note: Do not enroll any providers in this PCT as of 04/25/2001.

24.1 Class Type

020 - Outpatient Clinic

095 - Outpatient Clinic (out-of-state)

24.2 Speciality

076 - Other

24.3 Type of Agreement

Physician - Directed

24.4 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of license
  - Providers out-of-state and not within 50 miles of VA Border - A copy of the license from the state in which the provider practices must be submitted along with claims which will be used to determine period of enrollment.
  - SUBSTANCE ABUSE SPECIALTY - Providers requesting to enroll as a Substance Abuse Provider must submit proof of one of the following licenses/certificates before receiving a specialty of 47
    - Substance Abuse Counselor certified by the Board of Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals of DHP.
    - Addictions Counselor certified by the Substance Abuse Certification Alliance of VA, OR physician credentials, by the American Society of Addictions Medicine.

- ❖ Clinical Psychologist certified in the treatment of alcohol and other psychoactive substance abuse use disorders by the American Psychological Association.

24.5 Period of Enrollment

24.5.1 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
- Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.

24.5.2 End Date

- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.

24.6 Requirements

24.6.1 License Verification

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

  If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing

  If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor

- Licensing Requirement In-state - If the provider is an instate provider or within 50 miles of the VA Border, verify license through the Department of Health of VA Internet site: http://www.dhp.state.va.us/,

  Licensing Requirement out-of-state - If the provider is not within 50 miles of VA border, verify licensure via telephone or individual state's Department of Health Internet site. Most state Dept. of Health Internet Sites have a web site, www.docboard.org. Unless the provider is established as an on-going provider, copies of claim(s) necessitating enrollment must be attached.

- If license is active, proceed
- If license is not active RTP, stating “In order to enroll or re-enroll you must hold an active license through the State Board in which the practice is located". OR
- If license can not be verified, either via telephone or Internet Site, RTP, stating “In order to enroll provider must hold a valid license from the State Board in which the practice is located, please resubmit attached agreement with a current copy of license, or contact your State Board to obtain licensure.” OR
- If license is not legible; RTP, stating “ We could not verify licensure, please submit a legible copy of license".

24.6.2 Previous Enrollment

- Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADDds or Re-submit batch.

24.6.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, and the provider is not a Medallion provider, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file and provider is not a Medallion provider, make necessary changes.
- All Medallion address/telephone number changes go to the Medallion representative. The representative places a sticky not in [redacted] as to the action taken on providers re-enrollment.

24.6.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”
- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,”IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms”.
- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.
- If license has been verified, through DHP, or individual states licensing board, and provider is licensed into the future and not sanctioned by HCFA/CMS, you may begin to enter the agreement.
- If provider approved, create response letter for provider, and save onto provider’s file in [redacted]. Remember to PROFILE provider number on submitted information in [redacted], and correct Provider name if applicable. Use the DMAS stamp in the appropriate field on agreement form.
- If provider is rejected make sure to indicate ALL missing information on reply letter, verify grammar, and spelling prior to saving letter in [redacted] and mailing out to provider.
  - If PEU or PEU representative is unable to process a physician agreement, and has given it to another party to handle, please put a sticky note in [redacted] on agreement form as to what action was taken on that particular provider, and their enrollment.

24.7 Recertification

Make sure “Indefinite” agreement form filled out if it isnot reject-use Reject limited letter and send back blank indefinite agreements to provider.

If L/I indicator is “I”, agreement form is not required. If they have filled out an Indefinite agreement, and already have an “I” in indicator field on provider file, PEU will still verify and make any necessary corrections to provider file.

8. Verify the provider's signature is present on agreement form
    - ❖ If it is not RTP by checking box #3 on Reply letter indicating, “An original signature and date are required on agreement.”
    - ❖ If signature is present, proceed
9. Did the provider submit address information on agreement form?
    - ❖ If only a P.O. Box is listed on agreement form submitted for either physical or payment location, see if there is a non P.O. Box address already in system. If there is one in system, proceed and place the P.O. Box from agreement form in Payment address field on the provider file in CICS and move non P.O. Box address into Alternate address field on providers file. If address in CICS on providers file, and on agreement form are a P.O. Box only RTP. State on the reject letter. “In order to reenroll with VA Medicaid provider must have a servicing location that is not a P.O. Box, please resubmit attached agreement with address other than P.O. Box for servicing location.”
    - ❖ If only a payment location was given and it is not a P.O. Box, that is okay, more than likely it is the payment and servicing location, proceed
10. If payment address varies on agreement from what is already existing on provider file and they have a separate physical address, make necessary changes to payment address on provider file.
11. If payment/servicing location are the same and the address varies on the agreement from what is already on existing provider file, and the provider is not a Medallion provider, make necessary changes. Make sure that the FIPS code remains the same, if not change the FIPS code in provider file.
12. If the providers physical address varies on agreement from what is already on existing provider file and provider is not a Medallion provider, make necessary changes. Make sure that the FIPS code remains the same, if not change FIPS code on provider file.

13. If the provider's Phone number varies on agreement from what is already on existing provider file, make necessary changes. Only exception would be if provider were Medallion.
14. All Medallion address/telephone number changes go to Medallion representative. Make sure to place sticky notes in [redacted] as to action taken on providers re-enrollment.
    - ❖ Provider's specialty filled out on agreement form
      - – YES OR NO it is not necessary for provider to supply specialty information on a re-enrollment agreement form, proceed
      - – If specialty on agreement varies from specialty indicated on existing provider file, please see lead supervisor for special handling instructions, to determine if a new provider # is necessary.
    - ❖ IRS Identification Number written on agreement form
      - – YES, proceed
      - – If any part of IRS number is missing, or has to many numbers required of an IRS number, RTP, stating "IRS number on agreement form is either missing numbers, or has to many, please correct and resubmit for processing."
      - – If IRS number on agreement form varies from IRS number already on existing provider file RTP checking of box #1 on Reply Letter. Stating,"IRS identification number has changed, you will need to notify us in writing, to cancel this provider number. And request a new provider number by completing the enclosed blank agreement forms, or mark through provider number written on agreement form and checkbox in upper right hand corner on agreement form, requesting new number."
      - – If IRS number on agreement form varies from IRS number already on existing provider file, but they have checked box in upper right hand corner of agreement form requesting new number, cross out the provider number written on agreement form, and proceed to process a new number for provider. After new number is given, PEU representative will have to re-profile submitted information with new provider number given.
    - ❖ Does the provider have a telephone number given either on the agreement or on correspondence included?
      - – YES, proceed
      - – NO, not necessary for re-certification, as long as there is a phone number on the provider file. If there is not a phone number on provider file, review correspondence attached to see if telephone number was made available

and enter phone number in provider file. If no telephone number exists, return to provider, requesting phone number.

- ❖ If license has been verified through DHP, or individual states licensing board, and provider is licensed into the future and not sanctioned by HCFA/CMS, you may begin to enter the agreement.
- ❖ If Medicare Crossover and Vendor Number information has been supplied by provider, review Medicare Crossover information in manual to verify whether automatic crossover applies to provider, and proceed to process for Medicare Crossover, if applicable.
- ❖ If provider is approved, create response letter for provider and PROFILE provider number on submitted information in [redacted]. Use the DMAS stamp in the appropriate field on the agreement form.
- ❖ If provider is rejected, make sure to indicate ALL missing information is requested from provider. Also check word usage, and spelling prior to returning to provider and saving in [redacted].
- ❖ If PEU or PEU representative is unable to process a physician agreement, and has given it to another party to handle, please put a sticky note in [redacted] on agreement form as to what action was taken on that particular provider, and their re-enrollment.

- The information you enter in these fields is derived largely from the participation agreement.
- The provider's name is taken from the Name line.
- The provider's specialty is derived from information supplied by the provider at the bottom of the participation agreement.
- The provider's IRS number is found below the City/County information on the agreement form
- The eligibility begin date is derived either from the date of signature on the agreement or from the date requested by the provider or claim(s) submitted not going beyond 1 yr. in the past.
- The eligibility end date is not directly derived from the participation agreement. If the provider is requesting a specifically limited period of time for his enrollment, he may have entered it on the agreement; however, the end date is based on expiration date of licensure or if provider not within 50 miles of VA border claim(s) submitted.
- Once all required information has been entered on page 1 of the ADD screen, you can proceed to page two. Page 2 of the file contains the provider's payment and alternate addresses, as well as the provider's phone number. Required elements on page 2 are as follows:

- ❖ MPre-authorization notices are mailed to the alternate address. Additionally, there are times when a programmer specifically extracts the alternate address as the target for a mailing.

- The provider's address information is found on the participation agreement.
- If the provider supplies only one address, then that address is keyed into the Payment Address fields. If the provider's payment address is a Post Office box or drawer, the provider must have a physical (alternate) address.
  - ❒ If you accidentally key information (even a space) into an Alternate Address field when there is no alternate address to enter, you will have to use the End key to clear each of the alternate address fields. Otherwise, the system assumes that there are additional data elements to be added to these fields to complete the address, and you will not be able to complete processing unless the fields are cleared or an alternate address is added.
    - ❖ Do not use the spacebar to clear fields.

25.0 Detailed Enrollment Procedures – Outpatient Rehabilitation

OUTPATIENT REHABILITATION - PCT = 057

25.1 Class Type

057

25.2 Specialty

000

25.3 Type of Agreement

Outpatient Rehab

25.4 Attachments

- HCFA (Health Care Financing Administration) certification as Outpatient Rehab Agency or Physical Therapy Clinic-see NOTe for recertifications rule.
- Rates from Clifton Gunderson (MAP 140 form) – see NOTE on how to handle NEW PROVIDERS if rates are attached or not.

25.4.1 Begin Date

Beginning of month prior to date of receipt. For out-of-state providers, this will be the first date of service (based on submitted documentation). In no event should it be prior to effective date of license/certification.

25.4.2 End Date

- For HCFA there is no expiration date on certification, therefore they receive 5 years from begin date.
- For a NEW provider give them 5 years from effective date.
  - Example: If the provider's effective date is 08/31/2000, end date would be 07/31/2005
- If a provider is RECERTIFYING and HAS BEEN CANCELLED, give them 5 years from effective date.

- Example: If the provider's original end date in system is 07/31/2000, their new begin date would be 08/01/2000, and end date would be 07/31/2005 (5 years from new Begin date).

- If a provider is RECERTIFYING and HAS NOT BEEN CANCELLED, give them 5 years from their original end date.
  - Example: If a provider's end date is 03/28/01 in the system, and the current day is prior to their end date, the end date would be 01/31/2006.

Note: Individual therapists are NOT enrolled.

It is only in the most RARE circumstances that Virginia Medicaid will enroll an out-ofstate rehab agency. This would involve cooperation with the Quality Utilization Management Unit in placement of the recipient.

An outpatient rehab clinic operating on a hospital's premises (it's part of the hospital) would bill under the hospital's general acute care provider number (class type 01). If it's off-site, it is certified separately and would be enrolled as a class type 57.

RECERTIFICATION RULE

In most cases providers when re-certifying do not submit a copy of their HCFA certification. If a provider is re-certifying with VA Medicaid and they do not submit a copy of HCFACMS, it is the responsibility of the Provider Enrollment Unit to verify if we have a copy of their certification in our files, and to take appropriate action for each individual case.

CLIFTON GUNDERSON RATES:

IF THIS IS AN ADD AND, Provider has submitted HCFA and , enroll the provider, create letter, profile the new provider # in [redacted], then give the agreement along with return letter to supervisor, so they can add the rates onto the providers file. The supervisor will then place agreement and letter in outgoing mail.

, provider has submitted Clifton Gunderson rates, place agreement form along with everything submitted into the pend file to await rates. Once rates come in the supervisor will enroll them.

25.3 Requirements

25.3.1 Required data

- Application - Must be entirely completed
- Participation Agreement form
- Copy of HCFA certification as a Rural Health Clinic (RHC). For re-certification the provider may or may not submit a copy of HCFA certification.

25.3.2 Optional data

- For re-certifications a copy of HCFA.
- Copy of Clifton Gunderson rates.

25.3.3 License verification

- Verify the provider through the List of Excluded Individuals HCFA Sanction Internet site: http://www.os.dhhd.gov/progorg/oig/cumsan/
  - ❒ If the provider is not on the list, mark lower left hand corner on agreement form the date verified, and initials of representative, who verified that information, and proceed with processing
  - ❒ If the provider is on the list, notify and interoffice provider application to the DMAS Provider Enrollment Contract Monitor.

25.3.4 Is this an add?

- Was a copy of HCFA certification submitted?
  - ❒ YES, Proceed with processing
  - ❒ NO, RTP stating, “In order to enroll with VA Medicaid as a Rural Health Clinic, you must submit a copy of HCFA certification”.
- Were Clifton Gunderson Rates (MAP140 form) submitted?
  - ❒ YES, proceed with processing for provider number, establish provider number, create letter, profile the new number in [redacted], give the agreement along with response letter to supervisor, so they can add the rates onto the provider’s file. The supervisor will then place agreement and letter in outgoing mail/
  - ❒ No, place agreement form along with everything submitted into the pend file to await rates Once rates come in the supervisor will enroll them. (Provider Enrollment Unit can not enroll Rural Health Clinics unless Clifton Gunderson rates have been sent in)

25.3.5 Is this a Re-certification?

- Was HCFA certification submitted? (Providers are not required to submit HCFA certification for re-enrollment as in most cases it is already in [redacted])
  - ❒ YES, proceed with processing
  - ❒ NO, If they did not submit HCFA certification when re-certifying the Provider Enrollment Unit representative must verify in [redacted] whether there is HCFA certification on file.
    - ❖ If there is a copy of HCFA in [redacted], proceed with processing.
    - ❖ If there is not copy of HCFA in [redacted], RTP stating "In order to reenroll you must submit a copy of HCFA certification as a Rural Health Clinic".

If the provider is approved (Agreement form filled out completely, HCFA and, Clifton Gunderson Rates attached), use the DMAS stamp in the appropriate field on the agreement form,create response letter, add provider number to [redacted], then Give agreement along with everything submitted to supervisor to add rates to providers file.

After enrolling, the supervisor will email the provider number, name and effective dates to Clifton Gunderson. The e-mail address is marciacole@cliftoncpa.com. My preference would be for you to log on as VMAPPEU to do this.

26.0 Detailed Enrollment Procedures – Personal Care

Personal Care - PCT = 055

26.1 Class Type

055

26.2 Specialty

046

016

26.3 Type of Agreement

CBC Personal Care application Personal Care Participation Agreement Attachments

26.3.1 Begin Date

Beginning of month prior to date of receipt, or date requested by provider not to exceed 1 yr. in the past.

26.3.2 End Date

5 years

Note: No out-of state providers.Must be a facility not a business in the home. Nurse Aides are not enrollable.

27.0 Description of Personal Care Services Overview

Personal/respite care agencies provide services designed to prevent or reduce inappropriate institutional care by providing eligible individuals with personal/respite care aides who perform basic health-related services.

Personal care services are defined as long-term maintenance or support services which are necessary to enable the individual to remain at or return home rather than enter a nursing facility or hospital for a condition. Personal care services provide eligible individuals with personal care aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with normally self-administered medications, reporting changes in the recipient's conditions and needs, and/or providing household services essential to health in the home, or all of these. Specifically, personal care services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes. Personal/respite care services cannot be offered to individuals who are residents of nursing facilities, assisted living facilities, or adult foster homes licensed by the Department of Social Services.

Services will be offered only to individuals who have been certified eligible as an alternative to nursing facility or hospital level of care for a condition of AIDS/HIV+ and symptomatic by a Nursing Home Pre-Admission Screening Committee (NHPASC). The committee will have explored medical, social, and nursing needs of the individual, analyzed specific services the individual needs, and evaluated whether a service or combination of existing services is available to meet these needs. The Committee will have explored alternative settings and/or services to provide the required care before making the referral for personal/respite care services.

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who otherwise would have to be institutionalized. Virginia offers personal/respite care as a service option under two home and community-based care waivers: the Elderly and Disabled Waiver, and the Waiver for Individuals with AIDS. Under the Elderly and Disabled Waiver, services may be furnished only to persons:

1. Who meet the nursing facility or pre-nursing facility criteria;
2. Who are financially eligible for Medicaid;
3. For whom an appropriate Plan of Care can be established;
4. Who are not residents of nursing facilities, or homes for adults and adult foster homes licensed by the Department of Social Services; and

5. Where there are no other or insufficient community resources to meet the recipients' needs.

Under the waiver for individuals with AIDS or who are HIV+ and symptomatic, personal/respite care services may be furnished only to persons:

1. Who, without the receipt of services under the waiver, will require the level of care provided in a hospital or nursing facility;
2. Who have been diagnosed by a physician as having AIDS and are experiencing medical and functional symptoms associated with AIDS or are HIV+ and symptomatic;
3. Who are not residents of hospitals, nursing care facilities, or homes for adults and adult foster homes licensed by the Department of Social Services;
4. Who have dependencies in some areas of ADLs and for whom an appropriate Plan of Care can be developed which is expected to avoid more costly institutional services and ensure the individual's safety and welfare in the home and community;
5. Who are financially eligible for Medicaid; and,
6. Who have no other, or insufficient, community resources available to meet their needs.

To ensure that Virginia's waiver programs are offered only to individuals who would otherwise be placed in an institution, personal/respite care services can be considered only for individuals who are seeking nursing facility admission (or hospital admission for a condition of AIDS or HIV+ and symptomatic) or for individuals who are determined to be at risk of nursing facility admission (or hospital admission for a condition of AIDS or HIV+ and symptomatic) if community-based services are not offered. Personal care/respite services must be the critical service that enables the individual to remain at home rather than being placed in an institution.

The recipient's status as a recipient in need of personal/respite care services is determined by the Nursing Home Pre-Admission Screening Committee. For individuals with AIDS, AIDS Service Organizations also contract with DMAS to perform pre-admission screening, as well as local and acute care Screening Committees. A request for a pre-admission screening for nursing facility placement can be initiated by the individual who desires the requested care, a family member, physician, local health department or social services professional, or any other concerned individual in the community. The appropriate assessment instrument (DMAS-95 for elderly and disabled persons and the DMAS-113-A for persons with AIDS/HIV) must be completed in its entirety. The Nursing Home Pre-Admission Screening Authorization (DMAS-96) and the Screening Committee Plan of Care (the DMAS-97 for individuals authorized under the Elderly and Disabled Waiver or the DMAS-113B for individuals authorized under the AIDS/HIV+ and symptomatic waiver) must also be completed by the Committee and approved by the public health physician or attending physician, whichever is appropriate. Note: If the

provider receives a referral that indicates the recipient has an HIV+ or AIDS diagnosis, the DMAS-96 must indicate that the individual has been authorized for AIDS Waiver services. This is essential to assure that the agency receives the higher reimbursement rate available for services provided under this waiver.

The Screening Committee Plan of Care indicates the services needed, any special needs of the recipient and environment, and the support available to provide services. The Screening Committee will note the number of days per week that care is needed but will not authorize the amount of service each day. The Screening Plan of Care also serves as written notification to the recipient of the estimated patient pay responsibility, when this information is available at the time of the screening, and documents the recipient's choice of long-term care options and choice of provider. If personal/respite care services are authorized and there is more than one approved provider agency in the community willing and able to provide care, the individual must have the option of selecting the provider agency of his or her choice.

28.0 Requirements Overview

28.1 New Enrollments

CBC Application

A provider requesting to participate, should be sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application must be reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

1. If checked yes, must have provider type and number.
2. Must have the administrator's name.

Part B of the application

- Contacts: Only contact required is Person responsible for signing contract, others are optional
- Areas: Atleast one county or city must be listed.
- Ownership: The percentage must total 100%. Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.
- Other Federally Funded Programs: Required if N/A not checked.
- Agency Type: At least one item must be checked.
- Agency Services: At least one item must be checked.
- Requirements: If yes checked, must have the type of offense, name, and title ofindividual. If those items are given, route the documents to the lead (CBC mustreview them). Must be signed and dated.

Part C of the application

Personal/Respite Care

- Must have information on at least one individual.
- Optional.
- Must have at least one RN listed with a current license end date.
  - ❒ If the application and agreement are incomplete:

- ❖ Complete rejection letter and return all items to the provider

❒ If the CBC application is complete and the agreement is incomplete:

❒ Complete a rejection letter and return all items to the provider. If the CBC application is incomplete and the agreement is complete

❒ Complete a rejection letter and return all items to the provider.If the CBC application and the agreement are complete:

- ❖ Proceed with enrollment of provider.

28.2 New Enrollments – Participation Agreements

3. Required Data
   - ❖ Participation Agreement form - 1 original.
   - ❖ Signed in ink by the provider.
   - ❖ Physical address CANNOT be a P.O. box number.
   - ❖ A telephone number must be available.
     - – Faxes are not acceptable.

1. Does the provider have an actual address given for the physical location?
   - ❖ If only a P.O. Box is listed, RTP with reject letter.
   - ❖ If address is given, continue.
2. Does the provider have a telephone number given either on the agreement or on any correspondence included?
   - ❖ If a telephone number is NOT given, RTP with reject letter.
   - ❖ If number is given, continue.
3. Verify the provider's signature is present and in ink.
   - ❖ If signature is not present, RTP with reject letter.
     - – An example of the letter may be found in the Appendix under letters.
   - ❖ If signature is present, look in the provider's electronic folder to review additional submitted information
   - ❖ If the provider is approved, use the DMAS stamp in the appropriate field on the agreement form.

28.3 Re-Enrollments

The majority of CBC provider class types are certified for 2-year periods. If CBC assigned an effective date of 2/2/97, the eligibility end date would be 2/2/99. Since the system is not currently Y2K compliant, the license review date field is being utilized to maintain the true expiration date. For standard re-enrollments, then, you simply need to change the end year.

28.3.1 RecertificationRe-certification Requirements

- Complete a new application Complete a new agreement
- Providers are NOT required to attend the seminar

28.3.2 Changes in Ownership

If a CBC provider undergoes a change in ownership, the new owner must complete the initial multi-page application and have it approved by CBC (in the past, if there were no staffing changes, Enrollment would bypass this step; however, these will now be re-approved by CBC). Upon approval, the provider will complete a set of participation agreements and be issued a new provider number.

29.0 Detailed Enrollment Procedures – Personal Care

PHARMACY - PCT = 060, 096

29.1 Class Type

- 060
- 096 (Not currently used)

29.2 Specialty

000 (69 is used only if unit dose approved)

29.3 Type of Agreement

Pharmacy

29.3.1 Attachments

- In-State- VA Board of Pharmacy permit
- Out of state (WITHIN 50) – VA Board of Pharmacy permit, VA Board of Pharmacy Non-resident Pharmacy permit, or individual states license.
- Out of State (NOT WITHIN 50) VA Board of Pharmacy permit, VA Board of Pharmacy Non-resident permit, or individual states license. A claim or supporting documentation is only necessary for initial enrollment or re-enrollment for out of state providers (not within 50) who do not hold a license through the VA Board of Pharmacy.
- Mail order pharmacies, unit dose, point of sale – see note page 3.

29.3.2 Begin Date

- In-State-date requested within one year of current date, or begin of month prior to receipt date.
- Out of State (WITHIN 50)- date requested within one year of current date, or begin of month prior to receipt date.
- Out of State (NOT WITHIN 50)
  - If a provider has VA Board of Pharmacy permit or VA Board of Pharmacy permit, begin date will be date requested within one year of current date, or begin of month prior to receipt date. NEVER BEFORE LICENSE BEGIN DATE

- ❒ If provider has licensure from their individual state, begin date would be first date of service on claim(s) within one year of current date. NEVER BEFORE LICENSE BEGN DATE

29.3.3 End Date

- In State - Enter the actual license expiration date.
- Out of State (WITHIN 50) – Enter the actual license expiration date.
- Out of State (NOT WITHIN 50)
  - ❒ If a provider has VA Board of Pharmacy permit or VA Board of Pharmacy Non-resident permit enter actual license expiration date.
  - ❒ If a provider has licensure from their individual State, end date would be last date of services from claim(s) submitted

Note: For DHP pharmacy licenses, the leading 4 digits represent:

0201 In-state Pharmacy provider

0214 Non-resident Pharmacy provider

0202 Pharmacist-DMAS does not pay individual

Pharmacists only: pharmacy facilities

0206 Durable Medical Equipment

0215 Wholesaler In State-DMAS does NOT PAY

as pharmacy provider

0219 Wholesaler Out of State-DMAS does NOT

PAY as pharmacy provider

Pharmacies requesting point-of-sale must be enrolled as class type 60 even if they are physically located outside of VA.

Out of state pharmacies may bill POS. They must complete the signature waiver, form portion regarding Point of Sale. We will enroll them with PCT 60. SEE PAGE 20

29.4 Point-Of-Sale (POS)

Point of sale is new technology whereby a provider transmits his claim at the time the services are rendered, and the claim is adjudicated and a payment response is returned to the provider instantly.

At this time, POS is for in-state pharmacy class type only, but if an out-of-state provider requests POS we will enroll them with an in-state class type of 60. If an out-of-state provider was initially enrolled with VA Medicaid with an out-of-state PCT of 96, and requests to become eligible for POS we would re-enroll them with a new provider number under PCT 60.

In-State provider requesting POS-Point-of-Sale (PCT 60)

1. New Provider:
    - ❖ Must have POS marked off on Signature Waiver Form
    - ❖ Enter Y in the POS Authorized field on the V01A screen.
2. Active Provider:
    - ❖ Must have POS marked off Signature Waiver Form.
    - ❖ Use transaction V01C
    - ❖ Enter Y in the POS Authorized field on the V01C screen.

Unit Dose Dispenser to Nursing Facilities

Form Requested

1. When a pharmacy requests to be a unit dose dispenser, take the pharmacy's name, provider number, and address, and send the pharmacy a unit dose dispensing form.
2. To produce the form:
    - ❖ In word, click on the share drive, it is DATA on '[redacted].
    - ❖ Double click on the groups folder. Double click on the procedures folder.
    - ❖ Double click on unit dose request.
    - ❖ This is a form field letter. Enter the requested data by pressing tab to go from one field to another.
    - ❖ Enter the provider's medicaid number in the number field.
    - ❖ Enter the provider's name.
    - ❖ Enter the requester's name as the ATTN: line.
    - ❖ Enter the address.

- ❖ Place in basket for outgoing work completed

When UNIT DOSE FORM is received at VMAP PEU, and has not been reviewed by DMAS:

3. Inner-office to [redacted], DMAS Pharmacy Supervisor
1. Put "sticky note" in [redacted] that it was sent inneter-office to David Sheppard at DMAS, and date sent

When UNIT DOSE FORM is received at VMAP PEU, and has been reviewed by DMAS:

1. If there is an approval stamp from DMAS, enter 69 as the provider specialty code. This is unit dose dispensing for a pharmacy.
2. From a blank screen, type [v01c] [space] [the provider #] and press
   - ❖ Type 69 as the provider specialty in the second specialty field
   - ❖ Press zeros in it.
3. If there is a denial stamp from DMAS, see your supervisor

Note: Make sure unit dose form is imaged in [redacted] under pharmacies provider number.

Note: We will enroll Mail Order Pharmacies in the VA Medicaid program as long as they hold a VALID Non-Resident Pharmacy permit from the Virginia board of Pharmacy prior to enrollment.

30.0 Detailed Enrollment Procedures – Physician

PHYSICIAN - PCT = 020, 095

30.1 Class Type

20 - Physician

95 - Physician (out-of-state)

30.2 Type of Agreement

Participation

30.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of license
  - ❒ Providers out-of-state and not within 50 miles of VA Border - A copy of the license from the state in which the provider practices must be submitted along with claims which will be used to determine period of enrollment.
  - ❒ Substance Abuse Specialty Agency - Providers requesting to enroll as a Substance Abuse Provider must submit proof of one of the following licenses/certificates before receiving a specialty of 47
    - ❖ Substance Abuse Counselor certified by the Board of Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals of DHP.
    - ❖ Addictions Counselor certified by the Substance Abuse Certification Alliance of VA, OR physician credentials, by the American Society of Addictions Medicine.
    - ❖ Clinical Psychologist certified in the treatment of alcohol and other psychoactive substance abuse use disorders by the American Psychological Association.

30.4 Period of Enrollment

30.4.1 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.

- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
- Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.

30.4.2 End Date

- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.

30.5 Requirements

30.5.1 License Verification

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

  If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing

  If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor

- Licensing Requirement In-state - If the provider is an instate provider or within 50 miles of the VA Border, verify license through the Department of Health of VA Internet site: http://www.dhp.state.va.us/,

  Licensing Requirement out-of-state - If the provider is not within 50 miles of VA border, verify licensure via telephone or individual state's Department of Health Internet site. Most state Dept. of Health Internet Sites have a web site, www.docboard.org. Unless the provider is established as an on-going provider, copies of claim(s) necessitating enrollment must be attached.

- If license is active, proceed.
- If license is not active RTP, stating “In order to enroll or re-enroll you must hold an active license through the State Board in which the practice is located". OR
- If the license can not be verified, either via telephone or Internet site, RTP, stating, “In order to enroll provider must hold a valid license from the State Board in which the practice is located, please resubmit attached agreement with a current copy of license, or contact your State Board to obtain licensure,” or
- If license is not legible, RTP, stating, “We could not verify licensure, please submit a legible copy of license".

30.5.2 Previous Enrollment

- Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADD or Re-submit batch.

30.5.3 Recertifications

- If payment address varies on agreement from what already exists on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, and the provider is not a Medallion provider, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file and provider is not a Medallion provider, make necessary changes.
- All Medallion address/telephone number changes go to the Medallion representative. Places a sticky note in [redacted] as to the action taken on provider’s re-enrollment.

30.5.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”
- If the IRS number varies from the IRS number already on existing provider file, [redacted] checking off box #1 on Reply Letter stating,”IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms”.
- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number

is given, PEU representative will have to reprofile submitted information with new provider number given.

- If license has been verified, through DHP, or individual states licensing board, and provider is licensed into the future and not sanctioned by HCFA/CMS, you may begin to enter the agreement.
- If provider approved, create response letter for provider, and save onto provider's file in [redacted]. Remember to PROFILE provider number on submitted information in [redacted], and correct Provider name if applicable. Use the DMAS stamp in the appropriate field on agreement form.
- If provider is rejected make sure to indicate ALL missing information on reply letter, verify grammar, and spelling prior to saving letter in [redacted] and mailing out to provider.
  - ❒ If PEU or PEU representative is unable to process a physician agreement, and has given it to another party to handle, please put a sticky note in [redacted] on agreement form as to what action was taken on that particular provider, and their enrollment.

30.5.5 Recertification

Make sure "Indefinite" agreement form filled out if not reject-use Reject limited letter and send back blank indefinite agreements to provider.

If L/I indicator is "I", agreement form is not required. If they have filled out an Indefinite agreement, and already have an "I" in indicator field on provider file, PEU will still verify and make any necessary corrections to provider file.

1. Verify the provider's signature is present on agreement form
   - ❖ If it is not RTP by checking box #3 on Reply letter indicating "An original signature and date are required on agreement."
   - ❖ If signature is present, proceed
2. Did the provider submit address information on agreement form?
   - ❖ If only a P.O. Box is listed on agreement form submitted for either physical or payment location, see if there is a non P.O. Box address already in system. If there is one in system, proceed and place the P.O. Box from agreement form in Payment address field on provider file in CICS and move non P.O. Box address into Alternate address field on providers file. If address in CICS on providers file, and on agreement form are a P.O. Box only RTP. State on the reject letter. "In order to reenroll with VA Medicaid provider must have a servicing location that is not a P.O. Box, please resubmit attached agreement with address other than P.O. Box for servicing location."

- ❖ If only a payment location was given and it is not a P.O. Box, that is okay, more than likely it is the payment and servicing location, proceed
- ❖ If payment address varies on agreement from what is already existing on provider file and they have a separate physical address, make necessary changes to payment address on provider file.
- ❖ If payment/servicing location are the same and the address varies on the agreement from what is already on existing provider file, and the provider is not a Medallion provider, make necessary changes. Make sure that the FIPS code remains the same, if not change the FIPS code in provider file.
- ❖ • If the provider's physical address varies on agreement from what is already on existing provider file and provider is not a Medallion provider, make necessary changes. Make sure that the FIPS code remains the same, if not change FIPS code on provider file.
- ❖ If the providers Phone number varies on agreement from what is already on existing provider file, make necessary changes. Only exception would be if provider is Medallion.
- ❖ All Medallion address/telephone number changes go to Medallion representative. Make sure to place sticky notes in [redacted] as to action taken on provider's re-enrollment.

3. Provider's specialty filled out on agreement form
    - ❖ YES OR NO it is not necessary for provider to supply specialty information on a re-enrollment agreement form, proceed
    - ❖ If specialty on agreement varies from specialty indicated on existing provider file, please see lead supervisor for special handling instructions, to determine if a new provider # is necessary.
4. IRS Identification Number written on agreement form
    - ❖ YES, proceed
    - ❖ If any part of IRS number is missing, or has to many numbers required of an IRS number, RTP, stating "IRS number on agreement form is either missing numbers, or has to many, please correct and resubmit for processing."
    - ❖ If IRS number on agreement form varies from IRS number already on existing provider file RTP checking of box #1 on Reply Letter. Stating,"IRS identification number has changed, you will need to notify us in writing, to cancel this provider number. And request a new provider number by completing the enclosed blank agreement forms, or mark through provider number written on agreement form

and checkbox in upper right hand corner on agreement form, requesting new number."

5. Does the provider have a telephone number given either on the agreement or on correspondence included?

   - ❖ YES, proceed
   - ❖ NO, not necessary for re-certification, as long as there is a phone number on the provider file. If there isn't a phone number on provider file, review correspondence attached to see if telephone number was made available and enter phone number in provider file. If no telephone number exists, return to provider, requesting phone number.
   - ❖ If license has been verified through DHP, or individual states licensing board, and provider is licensed into the future and not sanctioned by HCFA/CMS, you may begin to enter the agreement.
   - ❖ If the Medicare crossover and the Vendor Number information has been supplied by the provider, renew the Medicare Crossover information manual to verify whether automatic crossover applies to provider, and process for Medicare Crossover, if applicable.
   - ❖ If provider is approved, create response letter for the provider and PROFILE provider number on the submitted information in [redacted]. Use the DMAS stamp in the appropriate field on the agreement form.
   - ❖ If provider is rejected, make sure to indicate ALL missing information is requested from provider. Also check word usage, and spelling prior to returning to provider and saving in [redacted].
   - ❖ If PEU or PEU representative is unable to process a physician agreement, and has given it to another party to handle, please put a sticky note in [redacted] on agreement form as to what action was taken on that particular provider, and their re-enrollment.

The information you enter in these fields is derived largely from the participation agreement.

The provider's name is taken from the Name line.

The provider's specialty is derived from information supplied by the provider at the bottom of the participation agreement.

The provider's IRS number is found below the City/County information on the agreement form

The eligibility begin date is derived either from the date of signature on the agreement or from the date requested by the provider or claim(s) submitted not going beyond 1 yr. in the past.

The eligibility end date is not directly derived from the participation agreement. If the provider is requesting a specifically limited period of time for his enrollment, he may have entered it on the agreement; however, the end date is based on expiration date of licensure or if provider not within 50 miles of VA border claim(s) submitted.

Once all required information has been entered on page 1 of the ADD screen, you can proceed to page two. Page 2 of the file contains the provider's payment and alternate addresses, as well as the provider's phone number. Required elements on page 2 are as follows:

Note: Pre-authorization notices are mailed to the alternate address. Additionally, there are times when a programmer specifically extracts the alternate address as the target for a mailing.

The provider's address information is found on the participation agreement.

If the provider supplies only one address, then that address is keyed into the Payment Address fields. If the provider's payment address is a Post Office box or drawer, the provider must have a physical (alternate) address.

Note: If you accidentally key information (even a space) into an Alternate Address field when there is no alternate address to enter, you will have to use the End key to clear each of the alternate address fields. Otherwise, the system assumes that there are additional data elements to be added to these fields to complete the address, and you will not be able to complete processing unless the fields are cleared or an alternate address is added. Do not use the spacebar to clear fields.

31.0 Detailed Enrollment Procedures – Podiatrist

PODIATRIST - PCT = 030

31.1 Class Type

030 - Podiatrist

31.2 Type of Agreement

Participation

31.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of license
  - ❒ Providers out-of-state and not within 50 miles of VA Border - A copy of the license from the state in which the provider practices must be submitted along with claims which will be used to determine period of enrollment.

31.4 Period of Enrollment

31.4.1 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
- Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.

31.4.2 End Date

- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.

31.5 Requirements

31.5.1 License Verification

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

  If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing

  If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor

- Licensing Requirement In-state - If the provider is an instate provider or within 50 miles of the VA Border, verify license through the Department of Health of VA Internet site: http://www.dhp.state.va.us/,

  Licensing Requirement out-of-state - If the provider is not within 50 miles of VA border, verify licensure via telephone or individual state's Department of Health Internet site. Most state Dept. of Health Internet Sites have a web site, www.docboard.org. Unless the provider is established as an on-going provider, copies of claim(s) necessitating enrollment must be attached.

- If license is active, proceed
- If license is not active RTP, stating “In order to enroll or re-enroll you must hold an active license through the State Board in which the practice is located". OR
- If license can not be verified, either via telephone or Internet Site, RTP, stating “In order to enroll provider must hold a valid license from the State Board in which the practice is located, please resubmit attached agreement with a current copy of license, or contact your State Board to obtain licensure.” OR
- If license is not legible, RTP, stating “ We could not verify licensure, please submit a legible copy of license".

31.5.2 Previous Enrollment

- Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADDs or Re-submit batch.

31.5.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- Ifthe payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file, make necessary changes.

31.5.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”
- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,”IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms”.
- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.
- If license has been verified, through DHP, or individual states licensing board, and provider is licensed into the future and not sanctioned by HCFA/CMS, you may begin to enter the agreement.
- If provider approved, create response letter for provider, and save onto provider’s file in [redacted]. Remember to PROFILE provider number on submitted information in [redacted], and correct Provider name if applicable. Use the DMAS stamp in the appropriate field on agreement form.
- If provider is rejected make sure to indicate ALL missing information on reply letter, verify grammar, and spelling prior to saving letter in [redacted] and mailing out to provider.

- ❒ If PEU or PEU representative is unable to process a physician agreement, and has given it to another party to handle, please put a sticky note in [redacted] on agreement form as to what action was taken on that particular provider, and their enrollment.

31.5.5 Recertification

Make sure "Indefinite" agreement form filled out if not reject-use Reject limited letter and send back blank indefinite agreements to provider.

If L/I indicator is "I", agreement form is not required. If they have filled out an Indefinite agreement, and already have an "I" in indicator field on provider file, PEU will still verify and make any necessary corrections to provider file

1. Verify the provider's signature is present on agreement form
    - ❖ If it is not RTP by checking box #3 on Reply letter indicating "An original signature and date are required on agreement."
    - ❖ If signature is present, proceed
2. Did the provider submit address information on agreement form?
    - ❖ If only a P.O. Box is listed on agreement form submitted for either physical or payment location, see if there is a non P.O. Box address already in system. If there is one in system, proceed and place the P.O. Box from agreement form in Payment address field on provider file in CICS and move non P.O. Box address into Alternate address field on providers file. If address in CICS on providers file, and on agreement form are a P.O. Box only RTP. State on the reject letter. "In order to reenroll with VA Medicaid provider must have a servicing location that is not a P.O. Box, please resubmit attached agreement with address other than P.O. Box for servicing location."
    - ❖ If only a payment location was given and it is not a P.O. Box, that is okay, more than likely it is the payment and servicing location, proceed
    - ❖ If payment address varies on agreement from what is already existing on provider file and they have a separate physical address, make necessary changes to payment address on provider file.
    - ❖ If payment/servicing location are the same and the address varies on the agreement from what is already on existing provider file, and the provider is not a Medallion provider, make necessary changes. Make sure that the FIPS code remains the same, if not change the FIPS code in provider file.
    - ❖ If the providers physical address varies on agreement from what is already on existing provider file and provider is not a Medallion provider, make necessary

changes. Make sure that the FIPS code remains the same, if not change FIPS code on provider file.

- ❖ If the providers Phone number varies on agreement from what is already on existing provider file, make necessary changes. Only exception would be if provider were Medallion.
- ❖ All Medallion address/telephone number changes go to Medallion representative. Make sure to place sticky notes in [redacted] as to action taken on provider's re-enrollment.

3. Provider's specialty filled out on agreement form
    - ❖ YES OR NO it is not necessary for provider to supply specialty information on a re-enrollment agreement form, proceed
    - ❖ If specialty on agreement varies from specialty indicated on existing provider file, please see lead supervisor for special handling instructions, to determine if a new provider # is necessary.
4. IRS Identification Number written on agreement form
    - ❖ YES, proceed
    - ❖ If any part of IRS number is missing, or has to many numbers required of an IRS number, RTP, stating "IRS number on agreement form is either missing numbers, or has to many, please correct and resubmit for processing."
    - ❖ If IRS number on the agreement form varies from IRS number already on existing provider file RTP checking of box #1 on Reply Letter. Stating,"IRS identification number has changed, you will need to notify us in writing, to cancel this provider number. And request a new provider number by completing the enclosed blank agreement forms, or mark through provider number written on agreement form and checkbox in upper right hand corner on agreement form, requesting new number."
    - ❖ If IRS number on agreement form varies from IRS number already on existing provider file, but they have checked box in upper right hand corner of agreement form requesting new number, cross out the provider number written on agreement form, and proceed to process a new number for provider. After new number is given, PEU representative will have to re-profile submitted information with new provider number given.
5. Does the provider have a telephone number given either on the agreement or on correspondence included?
    - ❖ YES, proceed

- NO, not necessary for re-certification, as long as there is a phone number on the provider file. If there isn't a phone number on provider file, review the correspondence attached to see if a telephone number was made available and enter the phone number in the provider file. If no telephone number exists, return to provider, requesting phone number.
- If the license has been verified through DHP, or individual states licensing board, and provider is licensed into the future and not sanctioned by HCFA, you may begin to enter the agreement.
- If the provider has supplied Medicare Crossover and Vendor Number information, review Medicare Crossover information in the manual to verify whether automatic crossover applies to the provider, and process for Medicare Crossover, if applicable.
- If the provider is approved, create response letter for provider and PROFILE provider number on submitted information in [redacted]. Use the DMAS stamp in the appropriate field on the agreement form.
- If provider is rejected, make sure to indicate ALL missing information is requested from provider. Also check word usage, and spelling prior to returning to provider and saving in [redacted].
- If PEU or PEU representative is unable to process a physician agreement, and has given it to another party to handle, please put a sticky note in [redacted] on agreement form as to what action was taken on that particular provider, and their re-enrollment.

The information you enter in these fields is derived largely from the participation agreement.

The provider's name is taken from the Name line.

The provider's specialty is derived from information supplied by the provider at the bottom of the participation agreement.

The provider's IRS number is found below the City/County information on the agreement form

The eligibility begin date is derived either from the date of signature on the agreement or from the date requested by the provider or claim(s) submitted not going beyond 1 yr. in the past.

The eligibility end date is not directly derived from the participation agreement. If the provider is requesting a specifically limited period of time for his enrollment, he may have entered it on the agreement; however, the end date is based on expiration date of licensure or if provider not within 50 miles of VA border claim(s) submitted.

Once all required information has been entered on page 1 of the ADD screen, you can proceed to page two. Page 2 of the file contains the provider's payment and alternate addresses, as well as the provider's phone number. Required elements on page 2 are as follows:

Note: MPre-authorization notices are mailed to the alternate address. Additionally, there are times when a programmer specifically extracts the alternate address as the target for a mailing.

The provider's address information is found on the participation agreement.

If the provider supplies only one address, then that address is keyed into the Payment Address fields. If the provider's payment address is a Post Office box or drawer, the provider must have a physical (alternate) address.

Note: If you accidentally key information (even a space) into an Alternate Address field when there is no alternate address to enter, you will have to use the End key to clear each of the alternate address fields. Otherwise, the system assumes that there are additional data elements to be added to these fields to complete the address, and you will not be able to complete processing unless the fields are cleared or an alternate address is added. Do not use the spacebar to clear fields.

32.0 Detailed Enrollment Procedures – Private Duty Nursing

PRIVATE DUTY NURSING - PCT = 063

32.1 Class Type

063

32.2 Specialty

046

016

32.3 Type of Agreement

CBC Private Duty Nursing application

Private Duty Nursing Participation Agreement

32.3.1 Attachments

- VDH (DOH) Center for Quality Healthcare Services and Consumer Protection for the specific site as a Home Health Agency OR
- JCAHO accreditation OR
- Adult Day Care Center license from DSS OR
- CHAP (Community Health Accreditation Program)

32.3.2 Begin Date

Standard begin.

32.3.3 End Date

- Up to 5 years.
- We are now Y2K compliant; enter the actual expiration date in the end eligibility date.

Note: No out-of state providers. Community-Base Care (CBC) providers have a two-stage enrollment process. A provider requesting to participate should be sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application

must be reviewed for completeness prior to enrolling. Effective 10/04/99, providers do not have to attend the seminar prior to being enrolled.

Note: RECERTS EFF. 08/08/00 - 10/22/00Only requirement is to have CBC application and participation agreement. No licensure needs to be verified.

32.4 Overview

Personal care services are defined as long-term maintenance or support services which are necessary to enable the individual to remain at or return home rather than enter a nursing facility or hospital for a condition of AIDS/HIV+ and symptomatic. Personal care services provide eligible individuals with personal care aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with normally self-administered medications, reporting changes in the recipient's conditions and needs, and/or providing household services essential to health in the home. Specifically, personal care services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes. Personal/respite care services cannot be offered to individuals who are residents of nursing facilities, homes for adults, or adult foster homes licensed by the Department of Social Services.

Services will be offered only to individuals who have been certified eligible as an alternative to nursing facility or hospital level of care for a condition of AIDS/HIV+ and symptomatic by a Nursing Home Pre-Admission Screening Committee (NHPASC). The committee will have explored medical, social, and nursing needs of the individual, analyzed specific services the individual needs, and evaluated whether a service or combination of existing services is available to meet these needs. The Committee will have explored alternative settings and/or services to provide the required care before making the referral for personal/respite care services.

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who otherwise would have to be institutionalized. Virginia offers personal/respite care as a service option under two home and community-based care waivers: the Elderly and Disabled Waiver, and the Waiver for Individuals with AIDS. Under the Elderly and Disabled Waiver, services may be furnished only to persons:

- Who meet the nursing facility or pre-nursing facility criteria;
- Who are financially eligible for Medicaid;
- For whom an appropriate Plan of Care can be established;

- Who are not residents of nursing facilities, or homes for adults and adult foster homes licensed by the Department of Social Services; and
- Where there are no other or insufficient community resources to meet the recipients' needs.

Under the waiver for individuals with AIDS or who are HIV+ and symptomatic, personal/respite care services may be furnished only to persons:

- Who, without the receipt of services under the waiver, will require the level of care provided in a hospital or nursing facility;
- Who have been diagnosed by a physician as having AIDS and are experiencing medical and functional symptoms associated with AIDS or are HIV+ and symptomatic;
- Who are not residents of hospitals, nursing care facilities, or homes for adults and adult foster homes licensed by the Department of Social Services;
- Who have dependencies in some areas of ADLs and for whom an appropriate Plan of Care can be developed which is expected to avoid more costly institutional services and ensure the individual's safety and welfare in the home and community;
- Who are financially eligible for Medicaid; and,
- Who have no other, or insufficient, community resources available to meet their needs.

To ensure that Virginia's waiver programs are offered only to individuals who would otherwise be placed in an institution, personal/respite care services can be considered only for individuals who are seeking nursing facility admission (or hospital admission for a condition of AIDS or HIV+ and symptomatic) or for individuals who are determined to be at risk of nursing facility admission (or hospital admission for a condition of AIDS or HIV+ and symptomatic) if community-based services are not offered. Personal care/respite services must be the critical service that enables the individual to remain at home rather than being placed in an institution.

The recipient's status as a recipient in need of personal/respite care services is determined by the Nursing Home Pre-Admission Screening Committee. For individuals with AIDS, AIDS Service Organizations also contract with DMAS to perform pre-admission screening, as well as local and acute care Screening Committees. A request for a pre-admission screening for nursing facility placement can be initiated by the individual who desires the requested care, a family member, physician, local health department, or social services professional, or any other concerned individual in the community. The appropriate assessment instrument (DMAS-95 for elderly and disabled persons and the DMAS-113-A for persons with AIDS/HIV) must be completed in its entirety. The Nursing Home Pre-Admission Screening Authorization (DMAS-96) and the Screening Committee Plan of Care (the DMAS-97 for individuals authorized under the Elderly and Disabled Waiver or the DMAS-113B for individuals authorized under the AIDS/HIV+ and symptomatic waiver) must also be completed by the Committee and approved by the public health physician or attending physician, whichever is appropriate. Note: If the

provider receives a referral that indicates the recipient has an HIV+ or AIDS diagnosis, the DMAS-96 must indicate that the individual has been authorized for AIDS Waiver services. This is essential to assure that the agency receives the higher reimbursement rate available for services provided under this waiver.

The Screening Committee Plan of Care indicates the services needed, any special needs of the recipient and environment, and the support available to provide services. The Screening Committee will note the number of days per week that care is needed but will not authorize the amount of service each day. The Screening Plan of Care also serves as written notification to the recipient of the estimated patient pay responsibility, when this information is available at the time of the screening, and documents the recipient's choice of long-term care options and choice of provider. If personal/respite care services are authorized and there is more than one approved provider agency in the community willing and able to provide care, the individual must have the option of selecting the provider agency of his or her choice.

32.5 Requirements

32.5.1 New Enrollments

CBC Application

A provider requesting to participate should be sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application must be reviewed for completeness prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

1. If checked yes, must have provider type and number.
2. Must have the administrator's name.

Part B of the application

- Contacts: Only contact required is Person responsible for signing contract , others are optional
- Areas: At least one county or city must be listed.
- Ownership: The percentage must total 100.
- Other Federally Funded Programs: Required if N/A not checked.
- Agency Type: At least one item must be checked.
- Agency Services: At least one item must be checked.

- Requirements: If yes checked, must have the type of offense, name and title of individual. If those items are given, route the documents to the lead (CBC must review them). Must be signed and dated.

Part C of the application – Personal/Respite Care

1. Must have information on at least one individual.
2. Optional.
3. Must have at least one RN listed with a current license date.

Part C of the application – Personal Attendant

1. Must have information on at least one individual.
2. Must have at least one individual listed with each column filled out.
3. N/A

Part C of the application – Adult Day Health Care

1. Must have information on at least one individual.
2. Must indicate number of aides, RN information, activities director information and director information.
3. Must indicate hours and days of operation.

Part C of the application – AIDS Case Management/Elderly Case Management

Must have information on at least one individual.

Part C of the application – Private Duty Nursing

1. Must have information on at least one individual.
2. Must have the number of staff filled out.
3. For the # on two, must have each column completed.

Part C of the application – Support Coordination

- Must have information on at least one individual.
  - ❒ If the application and the agreement are incomplete:
    - ❖ Complete a rejection letter and return all items to the provider.
  - ❒ If the CBC application is complete and the agreement is incomplete:
    - ❖ Complete a reject letter and return all submitted items to the applicant.

- If the CBC application is incomplete and the agreement is complete:
  - Complete a reject letter and return all submitted items to the applicant.
- If the CBC application and the agreement are complete:
  - Email Manager with the applicant's name, address, phone number and type of applicant. b. Send an approval letter indicating the new provider number and more information will be forthcoming in the mail regarding the seminar schedule.

32.6 New Enrollments

Participation Agreements – Returned 1.

1. Required data
   - Participation Agreement forms – one original.
   - Signed in ink by the provider.
   - Physical address CANNOT be a P.O. Box number.
   - A telephone number must be available.
   - VDH (DOH) Center for Quality Healthcare Services and Consumer Protection for that specific address as a Home Health Agency OR JCAHO accreditation OR Adult Day Care License from DSS. A homecare organization license is NOT acceptable.
     - Faxes are not acceptable.
2. Does the provider have an actual address given for the physical location?
   - If only a P.O. Box is listed, RTP with reject letter.
   - If address is given, continue.
3. Does the provider have a telephone number given either on the agreement or on any correspondence included?
   - If a telephone number is NOT given, RTP with reject letter.
   - If number is given, continue.
4. Verify the provider's signature is present and in ink.
   - If signature is not present, RTP with reject letter.
     - An example of the letter may be found in the Appendix under letters.
   - If signature is present, look in the provider's electronic folder to review additional submitted information.

5. If the provider is approved, use the DMAS stamp in the appropriate field on the agreement form.

32.7 Re-Enrollments

The majority of CBC provider class types are certified for 2-year periods. If CBC assigned an effective date of 2/2/97, the eligibility end date would be 2/2/99. Since the system is not currently Y2K compliant, the license review date field is being utilized to maintain the true expiration date.

For standard re-enrollments, then, you simply need to change the end year.

Recertification requirements

- complete a new application
- complete a new agreement with normal license requirements
- they are NOT required to attend the seminar

Changes in Ownership

If a CBC provider undergoes a change in ownership, the new owner must complete the initial multi-page application and have it approved by CBC (in the past, if there were no staffing changes, Enrollment would bypass this step; however, these will now be re-approved by CBC). Upon approval, the provider will complete a set of participation agreements and be issued a new provider number.

33.0 Detailed Enrollment Procedures – Prosthetic/Orthotic

PROSTHETIC/ORTHOTIC - PCT = 064

33.1 Class Type

064 - Prosthetic/Orthotic

33.2 Type of Agreement

Prosthetic and Orthotic

33.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Certificate
  - ❒ Certificate from the American Board for Certification on Orthotics and Prosthetics, or
  - ❒ Certificate from the Board for Orthotist/Prosthetist (BOC), OR
  - ❒ Copy of Business License

33.4 Period of Enrollment

33.4.1 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
- Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.

33.4.2 End Date

- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.

33.5 Requirements

33.5.1 License Verification

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

  If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing.

  If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor

33.5.2 Previous Enrollment

Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADDs or Re-submit batch.

33.5.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file, make necessary changes.

33.5.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”

- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,"IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms".
- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.
- If license has been verified, through DHP, or individual states licensing board, and provider is licensed into the future and not sanctioned by HCFA/CMS, you may begin to enter the agreement.
- If provider approved, create response letter for provider, and save onto provider's file in [redacted]. Remember to PROFILE provider number on submitted information in [redacted], and correct Provider name if applicable. Use the DMAS stamp in the appropriate field on agreement form.
- If provider is rejected make sure to indicate ALL missing information on reply letter, verify grammar, and spelling prior to saving letter in [redacted] and mailing out to provider.
  - ❒ If PEU or PEU representative is unable to process a physician agreement, and has given it to another party to handle, please put a sticky note in [redacted] on agreement form as to what action was taken on that particular provider, and their enrollment.

33.5.5 Recertification

Make sure "Indefinite" agreement form filled out if not reject-use Reject limited letter and send back blank indefinite agreements to provider.

If L/I indicator is "I", agreement form is not required. If they have filled out an Indefinite agreement, and already have an "I" in indicator field on provider file, PEU will still verify and make any necessary corrections to provider file.

1. Verify the provider's signature is present on agreement form
   - ❖ If it is not RTP by checking box #3 on Reply letter indicating "An original signature and date are required on agreement."
   - ❖ If signature is present, proceed
2. Did the provider submit address information on agreement form?
   - ❖ If only a P.O. Box is listed on agreement form submitted for either physical or payment location, see if there is a non P.O. Box address already in system. If there is one in system, proceed and place the P.O. Box from agreement form in

Payment address field on provider file in CICS and move non P.O. Box address into Alternate address field on providers file. If address in CICS on providers file, and on agreement form are a P.O. Box only RTP. State on the reject letter. "In order to reenroll with VA Medicaid provider must have a servicing location that is not a P.O. Box, please resubmit attached agreement with address other than P.O. Box for servicing location."

- ❖ If only a payment location was given and it is not a P.O. Box, that is okay, more than likely it is the payment and servicing location, proceed
  - – If payment address varies on agreement from what is already existing on provider file and they have a separate physical address, make necessary changes to payment address on provider file.
  - – If payment/servicing location are the same and the address varies on the agreement from what is already on existing provider file, and the provider theis not a Medallion provider, make necessary changes. Make sure that the FIPS code remains the same, if not change the FIPS code in provider file.
  - – If the providers physical address varies on agreement from what is already on existing provider file and provider is not a Medallion provider, make necessary changes. Make sure that the FIPS code remains the same, if not change FIPS code on provider file
  - – If the providers Phone number varies on agreement from what is already on existing provider file, make necessary changes. Only exception would be if provider were Medallion.
  - – All Medallion address/telephone number changes go to the Medallion representative. Make sure to place sticky notes in [redacted] as to action taken on providers reenrollment.

3. Provider's specialty filled out on agreement form
   - ❖ YES OR NO it is not necessary for provider to supply specialty information on are-enrollment agreement form, proceed
   - ❖ If specialty on agreement varies from specialty indicated on existing provider file, please see lead supervisor for special handling instructions, to determine if a new provider # is necessary.
4. IRS Identification Number written on agreement form
   - ❖ YES, proceed
   - ❖ If any part of IRS number is missing, or has to many numbers required of an IRS number, RTP, stating "IRS number on agreement form is either missing numbers, or has to many, please correct and resubmit for processing."

- ❖ If IRS number on agreement form varies from IRS number already on existing provider file RTP checking of box #1 on Reply Letter. Stating, ”IRS identification number has changed, you will need to notify us in writing, to cancel this provider number. And request a new provider number by completing the enclosed blank agreement forms, or mark through provider number written on agreement form and checkbox in upper right hand corner on agreement form, requesting new number.”
- ❖ If IRS number on agreement form varies from IRS number already on existing provider file, but they have checked box in upper right hand corner of agreement form requesting new number, cross out the provider number written on agreement form, and proceed to process a new number for provider. After new number is given, PEU representative will have to re-profile submitted information with new provider number given.

5. Does the provider have a telephone number given either on the agreement or on correspondence included?
   - ❖ YES, proceed
   - ❖ NO, not necessary for re-certification, AS LONG AS THERE IS A PHONE NUMBER ON THE PROVIDER FILE. If there isn’t a phone number on provider file, review correspondence attached to see if telephone number was made available and enter phone number in provider file. If no telephone number exists, return to provider, requesting phone number.
   - ❖ If license has been verified through DHP, or individual states licensing board, and provider is licensed into the future and not sanctioned by HCFA, you may begin to enter the agreement.
   - ❖ If Medicare Crossover and Vendor Number information has been supplied by the provider, review the Medicare Crossover information in the manual to verify whether automatic crossover applies to the provider, and process for Medicare Crossover, if applicable.
   - ❖ If the provider is approved, create a response letter for the provider and PROFILE the provider number on the submitted information in [redacted]. Use the DMAS stamp in the appropriate field on the agreement form.
   - ❖ If the provider is rejected, make sure to indicate all missing information is requested from the provider. Also, check word usage, and spelling prior to returning it to the provider and save it in [redacted].
   - ❖ If PEU or the PEU representative is unable to process a physician agreement, and has given it to another party to handle, please put a sticky note in [redacted] on

agreement form as to what action was taken on that particular provider, and their re-enrollment.

- The information you enter in these fields comes largely from the participation agreement.
- The provider's name is taken from the Name line.
- The provider's specialty is derived from information supplied by the provider at the bottom of the participation agreement.
- The provider's IRS number is found below the City/County information on the agreement form
- The eligibility begin date is derived either from the date of signature on the agreement or from the date requested by the provider or claim(s) submitted not going beyond one year in the past.
- The eligibility end date is not directly obtained from the participation agreement. If the provider is requesting a specifically limited period for his enrollment, he may have entered it on the agreement; however, the end date is based on expiration date of licensure or if provider not within 50 miles of VA border claim(s) submitted.
- Once all required information has been entered on page 1 of the ADD screen, you can proceed to page two. Page 2 of the file contains the provider's payment and alternate addresses, as well as the provider's phone number. Required elements on page 2 are as follows:
    - ❖ MPre-authorization notices are mailed to the alternate address. Additionally, there are times when a programmer specifically extracts the alternate address as the target for a mailing.
- The provider's address information is found on the participation agreement.
- If the provider supplies only one address, then that address is keyed into the Payment Address fields. If the provider's payment address is a Post Office box or drawer, the provider must have a physical (alternate) address.
    - ❒ If you accidentally key information (even a space) into an Alternate Address field when there is no alternate address to enter, you will have to use the End key to clear each of the alternate address fields. Otherwise, the system assumes that there are additional data elements to be added to these fields to complete the address, and you will not be able to complete processing unless the fields are cleared or an alternate address is added.
        - ❖ Do not use the spacebar to clear fields.

34.0 Detailed Enrollment Procedures – Outpatient Clinic

Psychiatrist- PCT = 020, 095

34.1 Class Type

020 - Physician

095 - Physician (out-of-state)

34.2 Type of Agreement

Participation

34.3 Speciality

71 - Psychiatry

34.4 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Certificate of completion of 3 years' residency for new providers
  - ❒ Verify if the provider has or has been previously enrolled with VA Medicaid and there is a certificate of residency before sending a letter requesting a copy. Verify under name of provider.
- Copy of DHP license
  - ❒ Providers out-of-state and not within 50 miles of VA Border - A copy of the license from the state in which the provider practices must be submitted along with claims which will be used to determine period of enrollment.

34.4.1 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.

- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
- Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.

34.4.2 End Date

- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.

34.5 Requirements

34.5.1 License Verification

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

  If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing.

  If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor

- Licensing Requirement In-state - If the provider is an instate provider or within 50 miles of the VA Border, verify license through the Department of Health of VA Internet site: http://www.dhp.state.va.us/,

  Licensing Requirement out-of-state - If the provider is not within 50 miles of VA border, verify licensure via telephone or individual state's Department of Health Internet site. Most state Dept. of Health Internet Sites have a web site, www.docboard.org. Unless the provider is established as an on-going provider, copies of claim(s) necessitating enrollment must be attached.

- If license is active, proceed

- If license is not active RTP, stating “In order to enroll or re-enroll you must hold an active license through the State Board in which the practice is located". OR
- If license can not be verified, either via telephone or Internet Site, RTP, stating “In order to enroll provider must hold a valid license from the State Board in which the practice is located, please resubmit attached agreement with a current copy of license, or contact your State Board to obtain licensure.” OR
- If license is not legible, RTP, stating “ We could not verify licensure, please submit a legible copy of license".

34.5.2 Previous Enrollment

Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADD or Re-submit batch.

34.5.3 Recertifications

- Do not RTP requesting copy of three year residency. Browse [redacted] to see if there is a copy on file.
- If payment address varies on the agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing location are the same and the address varies on the address form from what is already on existing provider file, and the provider is not a Medallion provider, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file and provider is not a Medallion provider, make necessary changes.
- All Medallion address/telephone number changes go to the Medallion representative. Places a sticky note in [redacted] as to the action taken on providers re-enrollment.

34.5.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has too many, please correct and resubmit for processing.”
- If the IRS number varies from the IRS number already on existing provider file, RTP checking off box #1 on Reply Letter stating,”IRS identification number has changed. You must notify us in writing, to cancel this provider number and request a new provider number by completing the enclosed enrollment forms”.

- If IRS number varies from IRS number already on existing provider file, but the provider is requesting a new number, proceed to process a new number for the provider. After new number is given, PEU representative will have to reprofile submitted information with new provider number given.

35.0 Detailed Enrollment Procedures – Renal Clinic

RENAL CLINIC - PCT = 050

35.1 Class Type

050 RENAL DIALYSIS CLINICClinics

35.2 Type of Agreement

Clinic

35.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of:
  - HCFA/Medicare certification as a Renal Dialysis Clinic (HDC)

35.4 Period of Enrollment

35.4.1 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
- Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.

35.4.2 End Date

- Effective end date for New Enrollees will be:
  - If the Provider has HCFA Certification the end date is five years from the begin date.
- Effective end date for Recertifications will be:
  - If a provider has not been cancelled, the end date is five years from the original end date.
  - If a provider has been cancelled, the end date is five years from the new begin date.
  - If the provider has HCFA certification, a certificate is not reissued unless the provider loses certification. Always verify that the Certificate is on file in [redacted] when recertifying.
- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.

35.5 Requirements

35.5.1 License Verification

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

  If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing.

  If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor

- If the license is active, proceed
- If the license is not active RTP, stating “In order to enroll or re-enroll you must hold an active license through the State Board in which the practice is located". OR

If license can not be verified, either via telephone or Internet site, RTP, stating “In order to enroll provider must hold a valid license from the State Board in which the practice is located, please resubmit attached agreement with a current copy of license, or contact your State Board to obtain licensure.” OR

If license is not legible, RTP, stating " We could not verify licensure, please submit a legible copy of license".

35.5.2 Previous Enrollment

- Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADDs or Re-submit batch.

35.5.3 Recertifications

Make sure "Indefinite" agreement form filled out if not reject-use Reject limited letter and send back blank indefinite agreements to provider.

If L/I indicator is "I", agreement form is not required. If they have filled out an Indefinite agreement, and already have an "I" in indicator field on provider file, PEU will still verify and make any necessary corrections to provider file.

1. Verify the provider's signature is present on agreement form
    - ❖ If it is not RTP by checking box #3 on Reply letter indicating "An original signature and date are required on agreement."
    - ❖ If signature is present, proceed
2. Did the provider submit address information on agreement form?
    - ❖ If only a P.O. Box is listed on agreement form submitted for either physical or payment location, see if there is a non P.O. Box address already in system. If there is one in system, proceed and place the P.O. Box from agreement form in Payment address field on the provider file in CICS and move non P.O. Box address into Alternate address field on providers file. If address in CICS on providers file, and on agreement form is a P.O. Box only RTP. State on the reject letter. "In order to reenroll with VA Medicaid provider must have a servicing location that is not a P.O. Box, please resubmit attached agreement with address other than P.O. Box for servicing location."
    - ❖ If only a payment location was given and it is not a P.O. Box, that is okay, more than likely it is the payment and servicing location, proceed
    - ❖ If payment address varies on agreement from what already exists on provider file and they have a separate physical address, make necessary changes to payment address on provider file.
    - ❖ If payment/servicing location are the same and the address varies on the agreement from what is already on existing provider file, and the provider theis

not a Medallion provider, make necessary changes. Make sure that the FIPS code remains the same, if not change the FIPS code in provider file.

- ❖ If the providers physical address varies on agreement from what is already on existing provider file and provider is not a Medallion provider, make necessary changes. Make sure that the FIPS code remains the same, if not change FIPS code on provider file.
- ❖ If the provider's Phone number varies on agreement from the existing provider file, make necessary changes. Only exception would be if provider were Medallion.
- ❖ All Medallion address/telephone number changes go to Medallion representative. Make sure to place sticky notes in [redacted] as to action taken on providers re-enrollment.

3. Provider's specialty filled out on agreement form
    - ❖ YES OR NO it is not necessary for provider to supply specialty information on a re-enrollment agreement form, proceed
    - ❖ If specialty on agreement varies from specialty indicated on existing provider file, please see lead supervisor for special handling instructions, to determine if a new provider # is necessary.
4. IRS Identification Number written on agreement form
    - ❖ YES, proceed
    - ❖ If any part of IRS number is missing, or has to many numbers required of an IRS number, RTP, stating "IRS number on agreement form is either missing numbers, or has to many, please correct and resubmit for processing."
    - ❖ If IRS number on agreement form varies from IRS number already on existing provider file RTP checking of box #1 on Reply Letter. Stating, "IRS identification number has changed, you will need to notify us in writing, to cancel this provider number. And request a new provider number by completing the enclosed blank agreement forms, or mark through provider number written on agreement form and checkbox in upper right hand corner on agreement form, requesting new number."
    - ❖ If IRS number on agreement form varies from IRS number already on existing provider file, but they have checked box in upper right hand corner of agreement form requesting new number, cross out the provider number written on agreement form, and proceed to process a new number for provider. After new number is given, PEU representative will have to re-profile submitted information with new provider number given.

5. Does the provider have a telephone number given either on the agreement or on correspondence included?
    - ❖ YES, proceed
    - ❖ NO, not necessary for re-certification, as long as there is a phone number on the provider file. If there isn't a phone number on provider file, review correspondence attached to see if telephone number was made available and enter phone number in provider file. If no telephone number exists, return to provider, requesting phone number.
6. If license has been verified through DHP, or individual states licensing board, and provider is licensed into the future and not sanctioned by HCFA/CMS, you may begin to enter the agreement.
    - ❖ If Medicare Crossover and Vendor Number information has been supplied by the provider, review the Medicare Crossover information in the manual to verify whether automatic crossover applies to the provider, and process for Medicare Crossover, if applicable.
    - ❖ If the provider is approved, create a response letter for the provider and PROFILE the provider number on the submitted information in [redacted]. Use the DMAS stamp in the appropriate field on the agreement form.
    - ❖ If the provider is rejected, make sure to indicate all missing information is requested from the provider. Also, check word usage, and spelling prior to returning it to the provider and save it in [redacted].
    - ❖ If PEU or the PEU representative is unable to process a physician agreement, and has given it to another party to handle, please put a sticky note in [redacted] on agreement form as to what action was taken on that particular provider, and their re-enrollment.

- The information you enter in these fields comes largely from the participation agreement.
- The provider's name is taken from the Name line.
- The provider's specialty is derived from information supplied by the provider at the bottom of the participation agreement.
- The provider's IRS number is found below the City/County information on the agreement form
- The eligibility begin date is derived either from the date of signature on the agreement or from the date requested by the provider or claim(s) submitted not going beyond one year in the past.

- The eligibility end date is not directly obtained from the participation agreement. If the provider is requesting a specifically limited period for his enrollment, he may have entered it on the agreement; however, the end date is based on expiration date of licensure or if provider not within 50 miles of VA border claim(s) submitted.
- Once all required information has been entered on page 1 of the ADD screen, you can proceed to page two. Page 2 of the file contains the provider's payment and alternate addresses, as well as the provider's phone number. Required elements on page 2 are as follows:
    - ❖ Pre-authorization notices are mailed to the alternate address. Additionally, there are times when a programmer specifically extracts the alternate address as the target for a mailing.
- The provider's address information is found on the participation agreement.
- If the provider supplies only one address, then that address is keyed into the Payment Address fields. If the provider's payment address is a Post Office box or drawer, the provider must have a physical (alternate) address.
    - ❒ If you accidentally key information (even a space) into an Alternate Address field when there is no alternate address to enter, you will have to use the End key to clear each of the alternate address fields. Otherwise, the system assumes that there are additional data elements to be added to these fields to complete the address, and you will not be able to complete processing unless the fields are cleared or an alternate address is added.
        - ❖ Do not use the spacebar to clear fields.

36.0 Detailed Enrollment Procedures – Residential Psychiatric Treatment

RESIDENTIAL PSYCHIATRIC TREATMENT - PCT = 077

36.1 Class Type

077

36.2 Specialty

36.3 Type of Agreement

Residential Psychiatric Treatment Agreement

36.3.1 Attachments

See note for specific requirements.

36.3.2 Begin Date

- Standard
- Never before 01/01/00

36.3.3 End Date

License expiration date.

Note: Out of State are treated the same. All providers wanting to participate are required to meet the standards and criteria listed below.

- Psychiatric Hospital: Must be accredited by one of the following: JCAHO, Commission on Accreditation of Services for Families, or the Council on Accreditation of Services for Families, AND MUST BE licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as a Residential Treatment Program.
- Inpatient Psychiatric Program in a Hospital: Must be accredited by one of the following: JCAHO, Commission on Accreditation of Services for Families, or the Council on Accreditation of Services for Families and

Children , and must be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as a Residential Treatment Program.

- Psychiatric Facility: Must be accredited by one of the following: JCAHO, Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children, and must be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as a Residential Treatment Program.

36.4 Requirements

7. Required data
    - ❖ Provider Application
    - ❖ Address Form with a physical address in the servicing address field
    - ❖ Participation Agreement forms - 1 original.
    - ❖ Signed in ink by the provider.
    - ❖ Physical address CANNOT be a P.O. box number.
    - ❖ A telephone number must be available.
    - ❖ Psychiatric Hospital: Must have copy of JCAHO and copy of DMHMRSAS license as a Residential Treatment Program for ADDS and RE-CERTIFICATION.
    - ❖ Inpatient Psychiatric Program in a Hospital: Must have copy of JCAHO and copy of DMHMRSAS license as a Residential Treatment Program for adds and re-certification.
    - ❖ Psychiatric Facility: Must have copy of JCAHO, or Commission on Accreditation of Rehabilitation Facilities, or Council on Accreditation of Services for Families and Children and copy of DMHMRSAS license as a Residential Treatment Program for adds and re-certification.
8. Does the provider have an actual address given for the physical location?
    - ❖ If only a P.O. Box is listed and this is an add, RTP with the reject letter.
    - ❖ If address is given, continue.
9. Does the provider have a telephone number given either on the agreement or on any correspondence included?
    - ❖ If a telephone number is NOT given and this is an ADD, RTP with reject letter.
    - ❖ If number is given, continue.

10. Verify the provider's signature is present and in ink.
    - ❖ If signature is not present and in ink, RTP with reject letter.
    - ❖ If signature is present, review additional submitted information.
11. For Psychiatric Hospital is there a copy of the DMHMRSAS license as a Residential Treatment Program and JCAHO?
    - ❖ If yes, continue.
    - ❖ If no, RTP with a reject letter.
12. For Inpatient Psychiatric Program in a Hospital is there a copy of DMHMRSAS license as a Residential Treatment Program and JCAHO?
    - ❖ If yes, continue
    - ❖ If no, RTP with reject letter
13. For Psychiatric Facility is there a copy of DMHMRSAS license as a Residential Treatment Program and JCAHO, or Commission on Accreditation Facilities, or the Council on Accreditation Services for Families and Children?
    - ❖ If yes, continue
    - ❖ If no, RTP with reject letter
14. If provider is approved use the DMAS stamp in the appropriate field on the agreement form.

37.0 Detailed Enrollment Procedures – Respite Care

Respite Care - PCT = 047

37.1 Class Type

047

37.2 Specialty

046

016

37.3 Type of Agreement

CBC Respite Care application

Respite Care Participation Agreement

37.4 Attachments

37.4.1 Begin Date

Beginning of month prior to date of receipt or date requested by provider not to exceed 1 yr. in the past.

37.4.2 End Date

5 years

Note: No out-of state providers. Nurse Aides are not enrollable. Must have a facility may not be a business run out of the home.

37.5 Overview

Personal/respite care agencies provide services designed to prevent or reduce inappropriate institutional care by providing eligible individuals with personal/respite care aides who perform basic health-related services.

Personal/respite care services are defined as long-term maintenance or supportive services which are necessary to enable the individual to remain at home rather than enter a nursing facility or hospital for a condition of AIDS/HIV+ and symptomatic. Although aides may provide care to recipients requiring skilled care, they cannot perform any services not outlined in the applicable provider manual.

Definition of Respite Care: Respite care is defined as services specifically designed to provide a temporary but periodic or routine relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. To receive services through this Program, the following criteria must be met:

- A primary caregiver who lives in the home and who requires temporary relief from the stress of continual caregiving;
- An incapacitated or dependent individual who requires continuous and long-term care due to advanced age or physical disability;
- In-home services which are designed to relieve the physical and emotional burdens of the caregiver and only secondarily the needs of the care receiver; and
- The prevention of individual and/or family breakdown and the consequent institutionalization which may result from the physical burden and emotional stress of providing continuous support and care to a dependent individual.

This definition distinguishes between respite care and the other services in the continuum of long-term care. The four concepts listed above focus on the need of the caregiver for temporary relief. This focus on the caregiver differentiates respite care from programs which focus on the dependent or disabled care receiver.

Services will be offered only to individuals who have been certified eligible as an alternative to nursing facility or hospital level of care for a condition of AIDS/HIV+ and symptomatic by a Nursing Home Pre-Admission Screening Committee (NHPASC). The committee will have explored medical, social, and nursing needs of the individual, analyzed specific services the individual needs, and evaluated whether a service or combination of existing services is available to meet these needs. The Committee will have explored alternative settings and/or services to provide the required care before making the referral for personal/respite care services.

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who otherwise would have to be institutionalized. Virginia offers personal/respite care as a service option under two home and community-based care waivers: the Elderly and Disabled Waiver, and the Waiver for Individuals with AIDS. Under the Elderly and Disabled Waiver, services may be furnished only to persons:

1. Who meet the nursing facility or pre-nursing facility criteria;
1. Who are financially eligible for Medicaid;
2. For whom an appropriate Plan of Care can be established;
3. Who are not residents of nursing facilities, or homes for adults and adult foster homes licensed by the Department of Social Services; and
4. Where there are no other or insufficient community resources to meet the recipients' needs.

Under the waiver for individuals with AIDS or who are HIV+ and symptomatic, personal/respite care services may be furnished only to persons:

1. Who, without the receipt of services under the waiver, will require the level of care provided in a hospital or nursing facility;
2. Who have been diagnosed by a physician as having AIDS and are experiencing medical and functional symptoms associated with AIDS or are HIV+ and symptomatic;
3. Who are not residents of hospitals, nursing care facilities, or homes for adults and adult foster homes licensed by the Department of Social Services;
4. Who have dependencies in some areas of ADLs and for whom an appropriate Plan of Care can be developed which is expected to avoid more costly institutional services and ensure the individual's safety and welfare in the home and community;
5. Who are financially eligible for Medicaid; and,
6. Who have no other, or insufficient, community resources available to meet their needs.

To ensure that Virginia's waiver programs are offered only to individuals who would otherwise be placed in an institution, personal/respite care services can be considered only for individuals who are seeking nursing facility admission (or hospital admission for a condition of AIDS or HIV+ and symptomatic) or for individuals who are determined to be at risk of nursing facility admission (or hospital admission for a condition of AIDS or HIV+ and symptomatic) if community-based services are not offered. Personal care/respite services must be the critical service that enables the individual to remain at home rather than being placed in an institution.

The recipient's status as a recipient in need of personal/respite care services is determined by the Nursing Home Pre-Admission Screening Committee. For individuals with AIDS, AIDS Service Organizations also contract with DMAS to perform pre-admission screening, as well as local and acute care Screening Committees. A request for a pre-admission screening for nursing facility placement can be initiated by the individual who desires the requested care, a family member, physician, local health department or social services professional, or any other concerned individual in the community. The appropriate assessment instrument (DMAS-95 for elderly and disabled persons and the DMAS-113-A for persons with AIDS/HIV) must be completed in its entirety. The Nursing Home Pre-Admission Screening Authorization (DMAS-96) and the Screening Committee Plan of Care (the DMAS-97 for individuals authorized under the Elderly and Disabled Waiver or the DMAS-113B for individuals authorized under the AIDS/HIV+ and symptomatic waiver) must also be completed by the Committee and approved by the public health physician or attending physician, whichever is appropriate. Note: If the provider receives a referral that indicates the recipient has an HIV+ or AIDS diagnosis, the DMAS-96 must indicate that the individual has been authorized for AIDS Waiver services. This is essential to assure that the agency receives the higher reimbursement rate available for services provided under this waiver.

The Screening Committee Plan of Care indicates the services needed, any special needs of the recipient and environment, and the support available to provide services. The Screening Committee will note the number of days per week that care is needed but will not authorize the amount of service each day. The Screening Plan of Care also serves as written notification to the recipient of the estimated patient pay responsibility, when this information is available at the time of the screening, and documents the recipient's choice of long-term care options and choice of provider. If personal/respite care services are authorized and there is more than one approved provider agency in the community willing and able to provide care, the individual must have the option of selecting the provider agency of his or her choice.

37.6 New Enrollments

CBC Application

A provider requesting to participate should be sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application must be reviewed for completeness prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

1. If checked yes, must have provider type and number.

2. Must have the administrator's name.

Part B of the application

- Contacts: Only contact required is Person responsible for signing contract , others are optional
- Areas: At least one county or city must be listed.
- Ownership: The percentage must total 100.
- Other Federally Funded Programs: Required if N/A not checked.
- Agency Type: At least one item must be checked.
- Agency Services: At least one item must be checked.
- Requirements: If yes checked, must have the type of offense, name and title of individual. If those items are given, route the documents to the lead (CBC must review them). Must be signed and dated.

Part C of the application – Personal/Respite Care

1. Must have information on at least one individual.
2. Optional.
3. Must have at least one RN listed with a current license date.
4. Must have the number of staff filled out.
5. For the # on 2, must have each column completed.

- If the application and agreement are incomplete:
  - Complete rejection letter and return all items to the provider
- If the CBC application is complete and the agreement is incomplete: a. Complete a rejection letter and return all items to the provider.
  - If the CBC application is incomplete and the agreement is complete: a. Complete a rejection letter and return all items to the provider.
- If the CBC application and the agreement are complete:
  - Proceed with enrollment of provider.

37.7 New Enrollments -- Participation Agreements

1. Required Data
    - ❖ Participation Agreement form - 1 original.
    - ❖ Signed in ink by the provider.
    - ❖ Physical address CANNOT be a P.O. box number.
    - ❖ A telephone number must be available.
        - – Faxes are not acceptable.
2. Does the provider have an actual address given for the physical location?
    - ❖ If only a P.O. Box is listed, RTP with reject letter.
    - ❖ If address is given, continue.
3. Does the provider have a telephone number given either on the agreement or on any correspondence included?
    - ❖ If a telephone number is NOT given, RTP with reject letter.
    - ❖ If number is given, continue.
4. Verify the provider's signature is present and in ink.
    - ❖ If signature is not present, RTP with reject letter.
        - – An example of the letter may be found in the Appendix under letters.
    - ❖ If signature is present, look in the provider's electronic folder to review additional submitted information
    - ❖ If the provider is approved, use the DMAS stamp in the appropriate field on the agreement form.

37.8 Re-Enrollments

The majority of CBC provider class types are certified for 2-year periods. If CBC assigned an effective date of 2/2/97, the eligibility end date would be 2/2/99. Since the system is not currently Y2K compliant, the license review date field is being utilized to maintain the true expiration date. For standard re-enrollments, then, you simply need to change the end year.

Recertification Requirements

- Complete a new application Complete a new agreement
- Providers are NOT required to attend the seminar

Changes in Ownership

If a CBC provider undergoes a change in ownership, the new owner must complete the initial multi-page application and have it approved by CBC (in the past, if there were no staffing changes, Enrollment would bypass this step; however, these will now be re-approved by CBC). Upon approval, the provider will complete a set of participation agreements and be issued a new provider number.

38.0 Detailed Enrollment Procedures – Rural Health Clinic (RHC)

RURAL HEALTH CLINIC (RHC) - PCT = 053

38.1 Class Type

053

38.2 Specialty

000

38.3 Type of Agreement

Physician-Directed

38.4 Attachments

- HCFA (Health Care Financing Administration) certification as Rural Health clinic-see NOTE for re-certifications rule.
- Rates from Clifton Gunderson (MAP 140 form)– see NOTE on how to handle new providers if rates are attached or not.
- Must have physician Directors DHP license either written on agreement form or a copy submitted.

38.4.1 Begin Date

- Beginning of month prior to date of receipt.
- For out-of-state providers, this will be the first date of service (based on submitted documentation).
- In no event should it be prior to effective date of license/certification.

38.4.2 End Date

- For HCFA there is no expiration date on certification, therefore, they receive 5 years from begin date.
- For a NEW provider give them 5 years from effective date.

Example: If the provider's effective date is 08/31/2000, end date would be 07/31/2005.

- If a provider is RECERTIFYINGRe-certifying and has NOT been cancelled, give them 5 years from their original end date.

Example: If a provider's end date is 03/28/01 in the system, and the current day is prior to their end date, the end date would be 01/31/2005

Note: If the provider wishes to perform dental services, the servicing dentist must enroll as a Dental Clinic provider. See the Dental Clinic Procedures for details.

RECERTIFICATIONRe-certification Rule:

In most cases providers when re-certifying do not submit a copy of their HCFA certification. If a provider is re-certifying with VA Medicaid and they do not submit a copy of HCFA it is the responsibility of the Provider Enrollment Unit to verify if we have a copy of their certification in our files, and to take appropriate action for each individual case.

Clifton Gunderson Rates:

IF THIS IS AN ADD AND, Provider has submitted HCFA and CLIFTON GUNDERSON RATES, enroll the provider, create letter, profile the new provider # in PCDOCS, then give the agreement along with return letter to supervisor, so they can add the rates onto the providers file. The supervisor will then place agreement and letter in outgoing mail.

If this is an ADD and, provider has submitted HCFA alone without Clifton Gunderson rates, place agreement form along with everything submitted into the pend file to await rates. Once rates come in the supervisor will enroll them.

Do not enroll these providers unless HCFA Certification, DHP License has been verified, and Clifton Gunderson rates are attached when submitted.

38.5 Requirements

1. Required data
   - ❖ Provider Application
   - ❖ Address Form with a physical address in the servicing address field
   - ❖ Participation Agreement form - 1 original.
   - ❖ Signed in ink by the provider.
     - – RHCs do NOT need a PROVIDER signature an administrator signature is acceptable.

- ❖ Copy of HCFA certification as a Rural Health Clinic (RHC). For re-certification the provider may or may not submit a copy of HCFA certification.
- ❖ Physician Directors DHP license number written on agreement form or copy of DHP license.
- ❖ Physical address CANNOT be a P.O. box number.
- ❖ A telephone number must be available. (Not required for re-certification)
- ❖ Faxes are not acceptable

2. Optional data
   - ❖ Copy of the physician director's medical license. Even if the license is provided, it is still confirmed with DHP.
   - ❖ For re-certifications a copy of HCFA.
3. License verification
   - ❖ Verify the provider through the List of Excluded Individuals HCFA Sanction Internet site: http://www.os.dhhd.gov/progorg/oig/cumsan/

     If the provider is not on the list, mark lower left hand corner on agreement form the date verified, and initials of representative, who verified that information, and proceed with processing

     If the provider is on the list, notify and interoffice provider application to the DMAS Provider Enrollment Contract Monitor.
4. Is this an ADD?
   - ❖ Was a copy of HCFA certification submitted?
     - – YES, Proceed with processing
     - – NO, RTP stating, "In order to enroll with VA Medicaid as a Rural Health Clinic, you must submit a copy of HCFA certification,
   - ❖ Was physician directors license number written on agreement or copy submitted?
     - – YES, proceed with processing
     - – NO, RTP stating, "In order to enroll with VA Medicaid a physician directors DHP license must be written on agreement form, or a copy submitted"
   - ❖ Were Clifton Gunderson Rates (MAP140 form) submitted?
     - – YES, proceed with processing for provider number, establish provider number, create letter, profile the new number in [redacted], and give the agreement along with response letter to supervisor, so they can add the

rates onto the provider's file. The supervisor will then place agreement and letter in outgoing mail/

- NO, place agreement form along with everything submitted into the pend file to await rates ONLY AFTER HCFA certification and DHP license have been verified. Once rates come in the supervisor will enroll them. (Provider Enrollment Unit can not enroll Rural Health Clinics unless Clifton Gunderson rates have been sent in)

5. Is this a re-certification?

   - ❖ Was the Physician Director's license written on agreement or copy submitted?
     - YES, verify license through DHP Licensure Database in MS Access or on DHP Internet site: http://www.dhp.state.va.us/
     - If license is active, proceed to verification of HCFA
     - NO, RTP to provider stating, "In order to re-enroll you must either submit a copy of physician directors license or write license number on agreement form.
   - ❖ Was the HCFA certification submitted? (Providers are not required to submit HCFA certification for re-enrollment as in most cases it is already in [redacted])
     - YES, , proceed with processing
     - NO, If they did not submit HCFA certification when re-certifying the Provider Enrollment Unit representative must verify in [redacted] whether there is HCFA certification on file.
   - ❖ If there is a copy of HCFA in [redacted], proceed with processing.
   - ❖ If there is not copy of HCFA in [redacted], RTP stating "In order to reenroll you must submit a copy of HCFA certification as a Rural Health Clinic".

6. Does the provider have a telephone number given on agreement?

   - ❖ If a telephone number is NOT given, RTP with reject letter. (if new provider, for recertification a telephone number is not necessary)
   - ❖ If telephone number given, proceed.

7. Verify the provider's signature is present and in ink on both agreements.

   - ❖ If signature is not present, RTP with reject letter.
   - ❖ If signature is present, review additional submitted information.
     - If the provider is approved (Agreement form filled out completely, HCFA and physician directors DHP license submitted, Clifton Gunderson Rates attached), use the DMAS stamp in the appropriate field on the agreement

form,create response letter, add provider number to [redacted], then Give agreement along with everything submitted to supervisor to add rates to providers file.

– After enrolling, the supervisor will email the provider number, name and effective dates to Clifton Gunderson. The e-mail address is [redacted]. My preference would be for you to log on as VMAPPEU to do this.

39.0 Detailed Enrollment Procedures – Ambulatory Surgical Care

SLH - AMBULATORY SURGICAL CARE - PCT = 049

39.1 Class Type

049

39.2 Type of Agreement

SLH ASC

39.3 Attachments

Medicaid Number Medicare certified

39.3.1 Begin Date

May 1 of the year prior to submission.

i.e., Rcv'd on 7-8-98, begin date would be 5-198.

i.e. Rcv'd on 2-8-99, begin date would be 5-198.

39.3.2 End Date

The same date as the Medicaid provider number.

39.3.3 Requirements

1. Required data
    - ❖ Provider Application
    - ❖ Address form with a physical address in the servicing address fields
    - ❖ Participation Agreement form.
    - ❖ Signed by the provider.
    - ❖ Physical address CANNOT be a P.O. box number.
    - ❖ A telephone number must be available.
    - ❖ Copy of Medicare certification AND JCAHO accreditation
    - ❖ Medicaid provider number given on claim

2. Does the provider have an actual address given for the physical location?
    - ❖ If only a P.O. Box is listed, RTP with reject letter.
    - ❖ If address is given, continue.
3. Does the provider have a telephone number given either on the agreement or on any correspondence included?
    - ❖ If a telephone number is NOT given, RTP with reject letter.
    - ❖ If number is given, continue.
4. Verify the provider's signature is present.
5. If signature is not present, RTP with reject letter.
        - An example of the letter may be found in the Appendix under letters.
    - ❖ If signature is present, look in the provider's electronic folder to review additional submitted information.
6. Is there a copy of the submitted Medicare certification in the electronic folder?
    - ❖ If yes, continue.
    - ❖ If no,
        - Did the provider indicate on the agreement that the facility is limited to an age group not eligible for Title XVIII benefits, but is accredited by the Joint Commission?
    - ❖ If yes, do the accreditation dates cover the dates of service? b) If no, continue.
7. Verify that the Medicaid provider number to ensure the number is active and for the appropriate class type.
    - ❖ If not, RTP with reject letter.
    - ❖ If so, continue.
8. If the provider is approved, use the DMAS stamp in the appropriate field on the agreement form.

39.4 Re-Enrollments

For standard re-enrollments, you simply need to change the end eligibility year and ensure the agreement indicates indefinite.

40.0 Detailed Enrollment Procedures – Health Department Clinic

SLH - HEALTH DEPARTMENT CLINIC - PCT = 51

40.1 Class Type

51 – SLH HEALTH DEPARTMENT CLINIC

40.2 Type of Agreement

SLH Health Department Clinic

40.3 Required Documents

- Provider Application - all information must be included
- Address Form with a physical address in the Servicing Address fields.
- Participation Agreement signed and dated by the provider
- Copy of:
  - ❒ HCFA/Medicare certification, and
  - ❒ JCAHO Accreditation

40.4 Period of Enrollment

40.4.1 Begin Date

- If physically located in VA, Begin Date will be beginning of month, prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and within 50 miles of VA Border, Begin date will be beginning of month, prior to date of receipt, or date requested by the provider, not to exceed 1 yr. in past from current date.
- If physically located outside of VA, and are NOT within 50 miles of VA Border: Begin date will be first date of service based on submitted claim(s), not to exceed 1 yr. in past from current date.
- Begin date will never be before initial license begin date.
- Do not give begin date greater then 1 year in the past from current date. If you have any exceptions, please see supervisor.

40.4.2 End Date

- Effective end date for New Enrollees will be:
  - If the Provier has HCFA Certification the end date is five years from the begin date.
- Effective end date for Recertifications will be:
  - If a provider has not been cancelled, the end date is five years from the original end date.
  - If a provider has been cancelled, the end date is five years from the new begin date.
  - If the provider has HCFA certification, a certificate is not reissued unless the provider loses certification. Always verify
  - that the Certificate is on file in [redacted] when recertifying.
- In state and out of state (within 50 miles of VA Border): Enter the actual license expiration date.
- Out of state providers (not within 50 miles of VA Border): the end date will be last date of service of claim(s) submitted.
- End date will never go beyond license expiration date.

40.5 Requirements

40.5.1 License Verification:

- Verify the provider's license through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

  If the provider is not on the list, check the appropriate box on the Application form, the date verified, your initials and proceed with processing.

  If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor

- If the license is active, proceed
  - If the license is not active RTP, stating “In order to enroll or re-enroll you must hold an active license through the State Board in which the practice is located". OR
  - If license can not be verified, either via telephone or Internet site, RTP, stating, “In order to enroll provider must hold a valid license from the State Board in which the practice is located, please resubmit attached agreement with a current copy of license, or contact your State Board to obtain licensure.” OR
  - If license is not legible, RTP, stating “ We could not verify licensure, please submit a legible copy of license".

40.5.2 Previous Enrollment

- Verify previous enrollments via alpha look up or IRS number look up in CICS. If number already exists, write duplicate on forms submitted and profile provider number on documentation submitted in ADD or Re-submit batch.

40.5.3 Recertifications

- If payment address varies on agreement from what is already existing on provider file and there is a separate servicing address, make necessary changes to payment address on provider file.
- If payment/servicing locations are the same and the address varies on the address form from what is already on existing provider file, make necessary changes.
- If the provider's servicing address varies from what is already on the existing provider file, make the necessary changes.

40.5.4 IRS Change Request

- If any part of the IRS number is missing, or has too many numbers required of an IRS number, RTP, stating “IRS number is either missing numbers, or has to many, please correct and resubmit for processing.”
- If the IRS number varies from the IRS number already existing on the provider file:
  - The provider may be changing the IRS number based upon a sale of the facility. If the buyer is assuming all IRS liability for the year and the Medicare Number is remaining the same, change the Tax ID and the provider will keep the same provider number.
  - The provider may be changing the IRS number as a matter of record and all other factors about the facility are not changing, i.e., Medicare Number, HCFA Certification, change the Tax ID and the provider will keep the same provider number
  - The provider may be changing the IRS number based upon a sale and a new Medicare number has been assigned, re-enroll the provider. The appropriate licensing and certification must accompany the application.

41.0 Detailed Enrollment Procedures – Substance Abuse Clinic

SUBSTANCE ABUSE CLINIC - PCT = 071

41.1 Class Type

071

41.2 Specialty

n/a

41.3 Type of Agreement

Substance Abuse Clinic

41.4 Attachments

Copy of substance abuse clinic license from DMHMRSAS

41.4.1 Begin Date

standard begin

41.4.2 End Date

License expiration date.

41.4.3 Agreement

Indefinite

Note: Out of State are treated the same.

41.5 Requirements

1. Required data
    - ❖ Provider Application
    - ❖ Address form with a physical address in the servicing address field
    - ❖ Participation Agreement forms

- ❖ Signed by the provider.
- ❖ A telephone number must be available.
- ❖ Copy of license from DMHMRSAS.

2. Does the provider have an actual address given for the physical location?
   - ❖ If only a P.O. Box is listed, RTP with reject letter.
   - ❖ If address is given, continue.
3. Does the provider have a telephone number given either on the appliction or on any correspondence included?
   - ❖ If a telephone number is NOT given, RTP with reject letter.
   - ❖ If number is given, continue.
4. Verify the provider's signature is present.
   - ❖ If signature is not present, RTP with reject letter.
     - An example of the letter may be found in the Appendix under letters.
   - ❖ If signature is present, look in the provider's electronic folder to review additional submitted information.
5. Is there a copy of the DMHMRSAS license in the electronic folder?
   - ❖ If yes, continue.
   - ❖ If no, RTP with a reject letter.
6. If the provider is approved, use the DMAS stamp in the appropriate field on the agreement form.

42.0 Detailed Enrollment Procedures – Support Coordinator

SUPPORT COORDINATOR - PCT = 073

42.1 Class Type

073

42.2 Specialty

017

42.3 Type of Agreement

CBC Support Coordinator application

Support Coordinator Participation Agreement

42.3.1 Begin Date

Beginning of month prior to date of receipt, or date requested by provider, not to exceed 1 yr. in past from current date.

42.3.2 End Date

5 years from begin date

Note: No out-of state providers. Must be a facility, not a business in the home. Nurse Aide's are not able, to be enrolled. Community-Base Care (CBC) providers have a two-stage enrollment process. A provider requesting to participate should be sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application must be reviewed for completeness prior to enrolling. Effective 10/04/99, providers do not have to attend the seminar prior to being enrolled.

42.4 New Enrollments

CBC Application

A provider requesting to participate, should be sent, the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application must be reviewed for completeness, prior to, enrolling.

Review the agreement at this time also for required fields.

Part A of the application

- If checked yes, must have provider type and number.
- Must have the administrator's name.

Part B of the application.

- Contacts: Only contact required is person responsible for signing contract, others are optional
- Areas: At least one county or city must be listed.
- Ownership: The percentage must total 100%. Exceptions: If a provider states on
- application that ownership is in stock the total may not equal 100%, or if they state they
- are a non-profit organization, they must submit a complete list of the Board of Directors.
- Other Federally Funded Programs: Required if N/A not checked.
- Agency Type: At least one item, must be checked.
- Agency Services: At least one item, must be checked.
- Requirements: If yes checked, must have the type of offense, name and title of individual. If those items are given, route the documents to the lead or supervisor. Must be signed and dated.

Part C of the application – Personal/Respite Care

- Must have information on at least one individual.
- Optional.
- Must have at least one RN listed with a current license date.

Part C of the application – Consumer Directed Service/Facilitator

- Must have information on at least one individual.
- Must have at least one individual listed with each column filled out.

Part C of the application – Adult Day Health Care

- Must have information on at least one individual.
- Must indicate number of aides, RN information, Activities Director information and Director information.
- Must indicate hours and days of operation.

Part C of the application – AIDS Case Management/Elderly Case Management

- Must have information on at least one individual.

Part C of the application – Private Duty Nursing

- Must have information on at least one individual.
- Must have the number of staff filled out.
- For the # on two, must have each column completed.

Part C of the application – Support Coordination

Must have information on at least one individual.

- If the application and the agreement are incomplete:
  - ❒ Complete a reject letter, and return all items to the provider.
- If the CBC application is complete and the agreement is incomplete:
  - ❒ Complete a reject letter, and return all submitted items to the applicant.
- If the CBC application is incomplete and the agreement is complete:
  - ❒ Complete a reject letter, and return all submitted items to the applicant.
- If the CBC application and the agreement are complete:

42.5 New Enrollments

Participation Agreements

1. Required data:
   - ❖ Provider Application
   - ❖ Address Form with a physical address in the servicing address fields
   - ❖ Participation Agreement form - 1 original.
   - ❖ Signed in ink by the provider.
   - ❖ Physical address CANNOT be a P.O. Box number.

- ❖ Faxes are acceptable

2. License Verification:
   - ❖ Verify the provider through the List of Excluded Individuals HCFA Sanction Internet site: http://exclusions.oig.hhs.gov/search.html

     If the provider is not on the list, mark in lower left hand corner on agreement form the date verified, and initials of representative, who verified that information, and proceed with processing.

     If the provider is on the list, notify and interoffice provider enrollment application to the DMAS Provider Enrollment Contract Monitor.
3. Does the provider have an actual address given for the physical location?
   - ❖ If only a P.O. Box is listed, RTP with reject letter.
   - ❖ If address is given, continue.
4. Does the provider have a telephone number given either on the agreement or on any correspondence included?
   - ❖ If a telephone number is NOT given, RTP with reject letter.
   - ❖ If number is given, continue.
5. Verify the provider's signature is present
   - ❖ If signature is not present, RTP with reject letter.
     - An example of the letter may be found in the Appendix under letters.
   - ❖ If signature is present, look in the provider's electronic folder to review additional submitted information.
6. If the provider is approved, use the DMAS stamp in the appropriate field on the agreement form.

42.5.1 Re-Enrollments

For standard re-enrollments, then, you simply need to change the end year. Recertification requirements are:

- complete a new application
- have an indefinite agreement

42.5.2 Changes in Ownership

If a CBC provider undergoes a change in ownership, the new owner must complete the initial multi-page application and have it approved by CBC (in the past, if there were no staffing changes, Enrollment would bypass this step; however, these will now be re-approved by CBC). Upon approval, the provider will complete a set of participation agreements and be issued a new provider number.

First Health Services Corporation®
A Coventry Health Care Company

Appendix F
Provider Groups Enrollment Manual

Version 1.1

June 12, 2008

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HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments

Table of Contents

HIPAA Privacy Rules 2
Revision History 3
Table of Contents 4
1.0 Detailed Enrollment Procedures 5
1.1 Description 5
1.2 General Rules 6
1.3 Required Documents 6
1.4 Optional Documents 6
1.5 Enter Provider Data into VaMMIS Application Tracking 6
1.6 Enter Provider Group Data 15
1.6.1 Task Description 15
1.6.2 Procedures 16
1.6.3 Complete Required Screens to Enroll Provider Group 17
1.6.4 Provider Information Screen Prompts 19
1.6.5 Group/Provider Maintenance Screen 33
1.6.6 Group/Provider Maintenance Screen Prompts (Data Labels) 33
2.0 Group Re-enrollment Packets 35
2.1 Split Re-Enrollment Tracking Groups 35
2.1.1 Re-enrollment Tracking: 35
2.2 Incomplete Re-Enrollment Tracking Rosters 36
2.2.1 Enrollment 36
2.2.2 Re-enrollment 36
2.3 Roster Providers Identified “Exclude” 36
2.3.1 Enrollment 37
2.4 Missing Required Documents 37
2.4.1 Enrollment 37
2.4.2 Re-enrollment Tracking 37

1.0 Detailed Enrollment Procedures

Enroll Provider Groups

PROVIDER GROUP – PCT = 020, 021, 023, 025, 026, 030, 031, 032, 034, 035, 036, 040, 044, 061, 064, 073, 076, 095, 097, 099, 101, 102,

1.1 Description

A Provider Group allows multiple servicing providers to bill and be paid under one Provider Medicaid Number. All individual providers in the group must be actively enrolled in the Virginia Medicaid program. On a provider group enrollment, each individual provider's name and NPI must be entered into the Provider Group Table of the Enrollment Application. Additionally, each individual provider entered into the Provider Group Table must sign a Reassignment of Benefits Form to acknowledge that they will become part of that provider group.

Provider Groups may be formed with any combination of the following provider types:

- Audiologist (PCT 044)
- Case Management (PCT 036)
- Case Management Waiver (PCT 073)
- Chiropractor (PCT 026)
- Clinical Nurse Specialist – Psychiatric Only (PCT 034)
- Clinical Psychologist (PCT 025)
- Dentist (PCT 040)
- Family Caregiver Training (PCT 061)
- Licensed Clinical Social Worker (PCT 076)
- Licensed Professional Counselor (PCT 021)
- Marriage and Family Therapist (PCT 102)
- Nurse Midwife (PCT 035)
- Nurse Practitioner (PCT 023)
- Optician (PCT 032)
- Optometrist (PCT 031)
- Out-of-State Dentist (PCT 097)
- Out-of-State Physician (PCT 095)
- Physician (PCT 020)
- Podiatrist (PCT 030)

- Prosthetic Services (PCT 064)
- Qualified Medicare Beneficiary (PCT 099)
- School Psychologist (PCT 101)

1.2 General Rules

- For PCT 073 and 099, the group participants must be individuals only, not businesses.
- APINs and Program Code 10 providers can not be enrolled as groups.
- The group name must be a business name, not an individual name.
- If the group is being enrolled in response to a Re-enrollment Group Packet, the Re-enrollment Tracking Number must be entered into the Application Tracking screen.
- If the group response to a Re-enrollment Group Packet requests splitting the 88 group into multiple billing groups, each group enrolled must include the Re-enrollment Tracking Number from the group packet that was mailed originally.

1.3 Required Documents

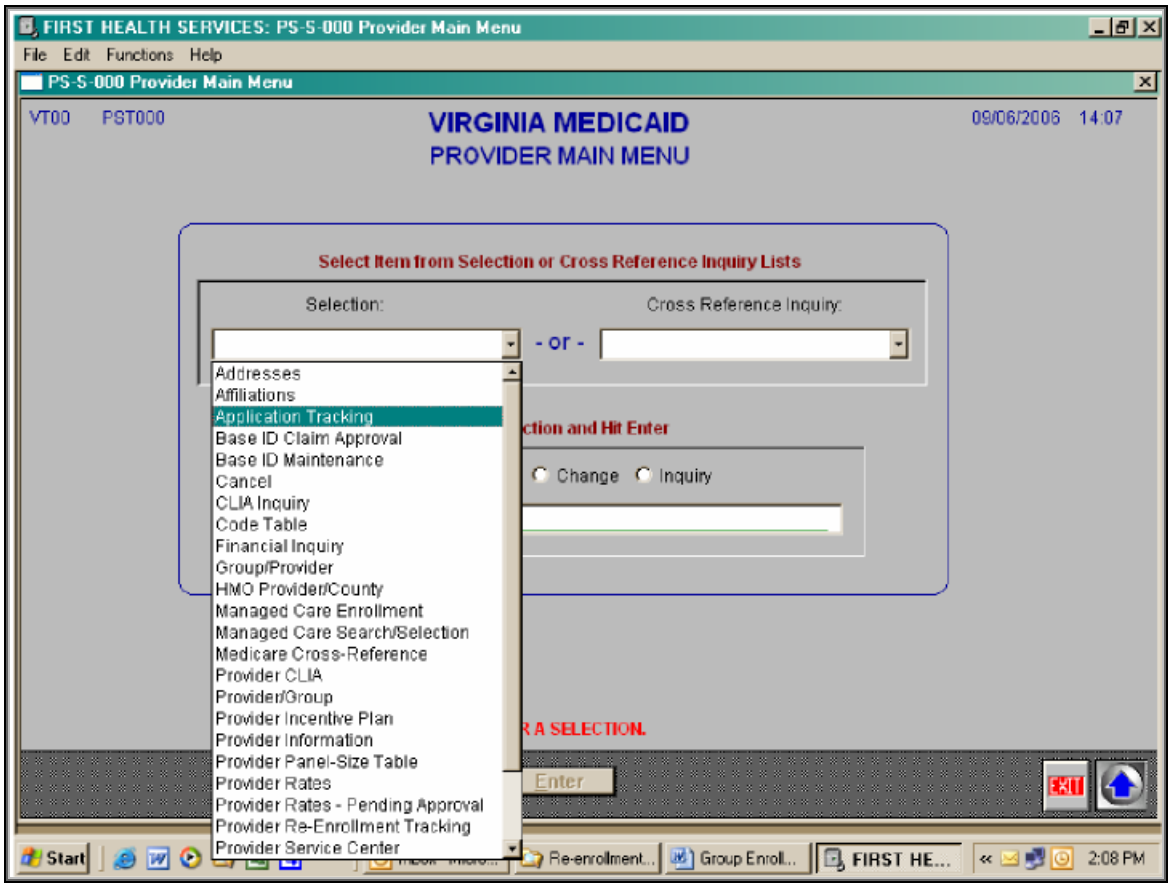
- Provider Group Enrollment Application
- Reassignment of Benefits Form (A completed form is required for each individual provider to be added to the Provider Group)
- Provider Group Participation Agreement
- W-9 Form for the Group or Organization

1.4 Optional Documents

- Mailing Suspension Request/Signature Waiver/Pharmacy Point-of-Sale Authorization Form
- Title XVIII (Medicare) Information Form
- Electronic Funds Transfer Application
- Provider Service Center Authorization Form

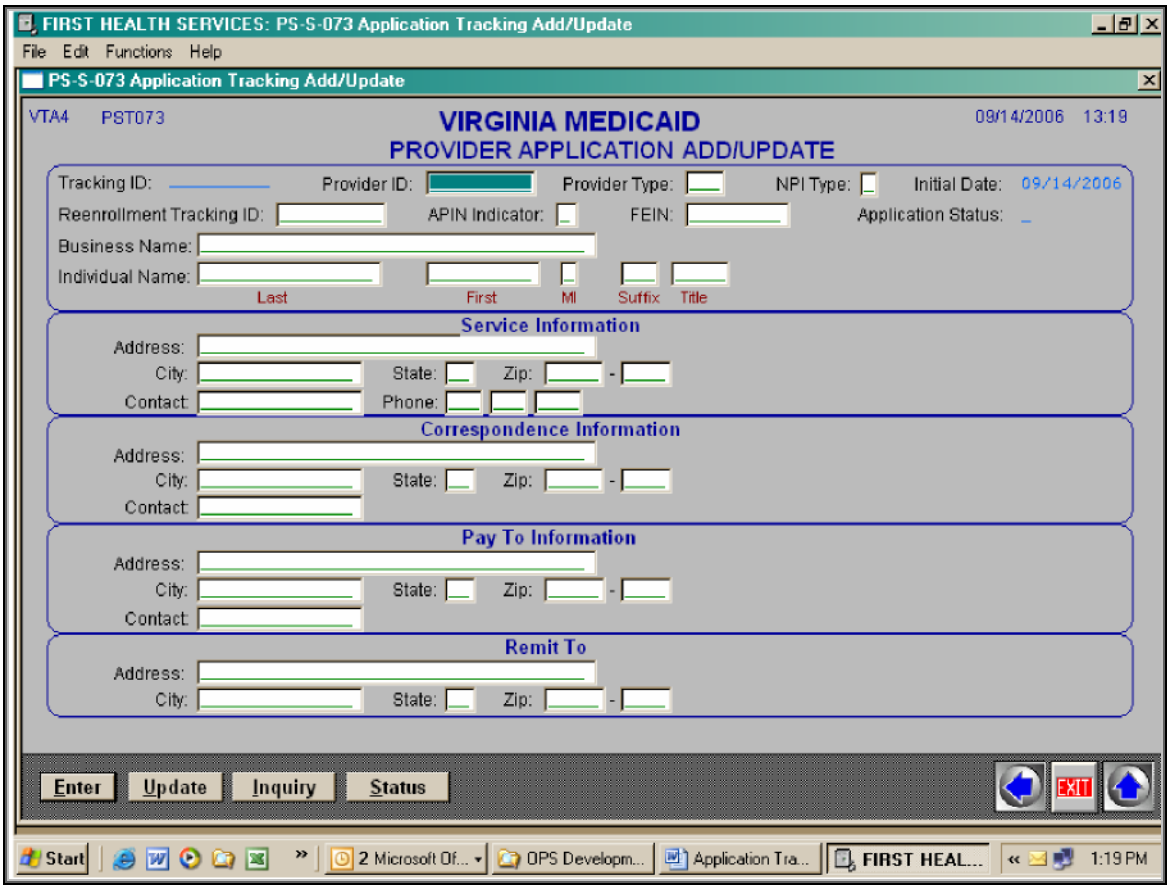
1.5 Enter Provider Data into VaMMIS Application Tracking

1. From the Provider Main Menu, enter the following selections:
    - ❖ From the Selection drop down box, select Application Tracking
    - ❖ Select “Add” from the Function options
    - ❖ Hit “Enter”



2. From the Provider Application Tracking Menu, enter the following selections:

   - From the Selection drop down box, select Application Tracking Add/Update
   - Select “Add” from the Function options
   - Hit “Enter”. You see the following screen.



3. Enter Provider Data

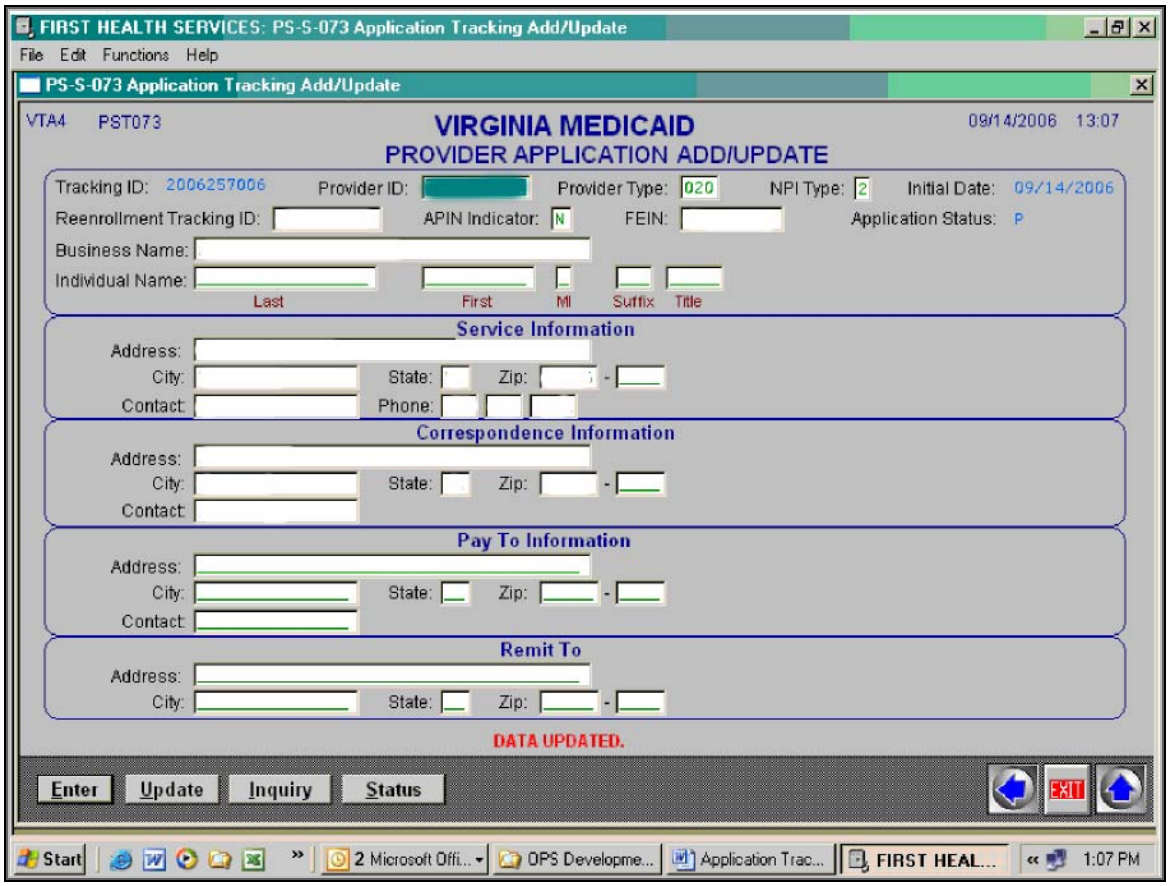
Screen	Data Element	Description	Value You Key	Comments
PS-S-073	Tracking ID	Displays the new Sequence number generated to make the Provider Application Tracking Number unique in the Provider Application Tracking database when a new provider application is created using the ADD transaction.	N/A	System Assigned

Screen	Data Element	Description	Value You Key	Comments
PS-S-073	Provider ID	This field is used to enter the group provider's 10-digit NPI.	Enter the Provider Group NPI from the Group Application.	NPI is a required field. If the NPI is not entered, or if the NPI is not in the appropriate format, the application will be rejected.
PS-S-073	Provider Type	The provider group PCT.	Enter the PCT that corresponds to the PCT of the majority of the group members.	See the list at the beginning of this section of provider PCT codes that are allowed to participate as groups. Required field.
PS-S-073	NPI Type	The NPI entity type: 1 = Individual 2 = business.	Enter "2 "for NPI business entity	Required field.
PS-S-073	Initial Date	Displays the date that the application was entered into the system.	N/A	System Assigned
PS-S-073	Re-enrollment Tracking ID	For Group Re-enrollment Packet responses, the re-enrollment tracking number assigned to the packet.	Enter the Re-enrollment tracking number from the group packet. If this is a new group not related to re-enrollment, leave the field blank.	If the re-enrollment tracking number is not entered for a group packet, the group record will not be linked to the Re-enrollment Tracking System group NPI data.

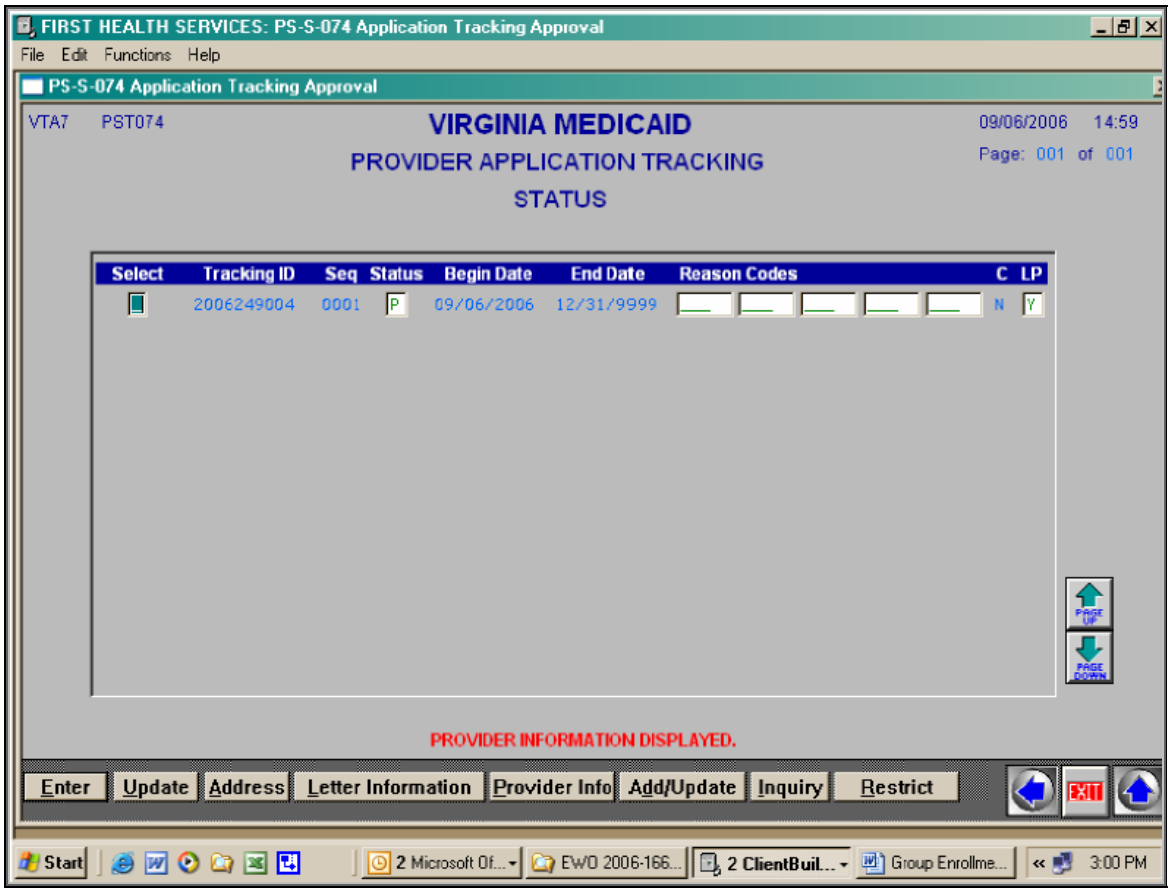
Screen	Data Element	Description	Value You Key	Comments
PS-S-073	APIN Indicator	The APIN Indicator that determines if Provider Application Number is eligible to have correspondence sent out.	“N”	Defaults to N if not entered. Groups cannot be Program 10 providers.
PS-S-073	FEIN	Federal Employer Identification Number (FEIN).	Enter the provider’s FEIN	Must be numeric and 9 characters long. Required field.
PS-S-073	Application Status	Displays the provider application status code. ("A" Approved, "D" Denied, "P" Pending, "R" Rejected)	N/A	System Assigned
PS-S-073	Business Name	The provider business name.	Enter the full business name of the group in this field.	Group name must be a business name. Required field.
PS-S-073	Individual Name Fields	Last Name, First Name, MI, Suffix, and Title fields.	N/A	Group name cannot be an individual name.
PS-S-073	Service Information Fields	Address, City, State, Zip, Contact and Phone fields.	Enter the group provider’s Servicing address information.	Address field is required. Phone field is optional.
PS-S-073	Correspondence Information	Address, City, State, Zip, and Contact fields.	Enter the group provider’s Correspondence address information.	Correspondence address is required. If not supplied on the form, enter the servicing address.
PS-S-073	Pay To Information	Address, City, State, Zip, and Contact fields.	Enter the provider’s Pay To address information.	

Screen	Data Element	Description	Value You Key	Comments
PS-S-073	Remit To Information	Address, City, State, and Zip fields.	Enter the provider's Remit To address information.	If the Remit To address is the same as the Pay To address, do not enter the Remit To address.

4. After Application Tracking data has been entered, click "Enter" to view edits. Correct any errors that can be corrected.
5. If the Re-enrollment Tracking number was entered but a message is displayed: RE-ENROLLMENT TRACKING ID NOT FOUND, verify that you have keyed the number correctly.
    - ❖ If keyed in error, correct the keying.
    - ❖ If the error still is displayed, exit the screen and access the Reenrollment Tracking Inquiry screen to verify that the tracking number exists in the database.
    - ❖ If the number is found in Re-enrollment Tracking, return to Application Tracking and re-enter the application. If the error still displays, contact your supervisor who will report the problem to systems.
    - ❖ If the number is not found in Re-enrollment Tracking, but is preprinted on the Re-enrollment Tracking Roster, contact your supervisor who will report the problem to systems.
6. Once errors are corrected, click Update.

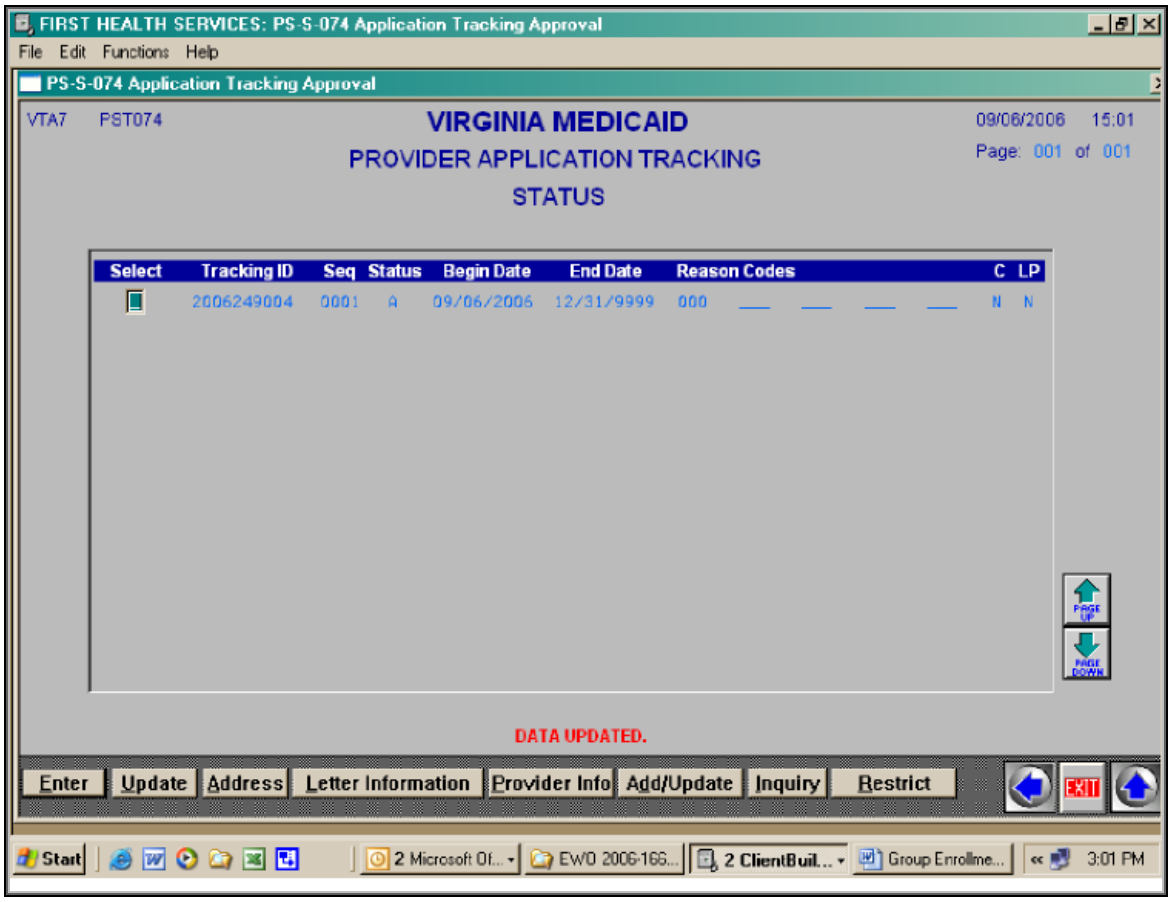


7. Click Status.

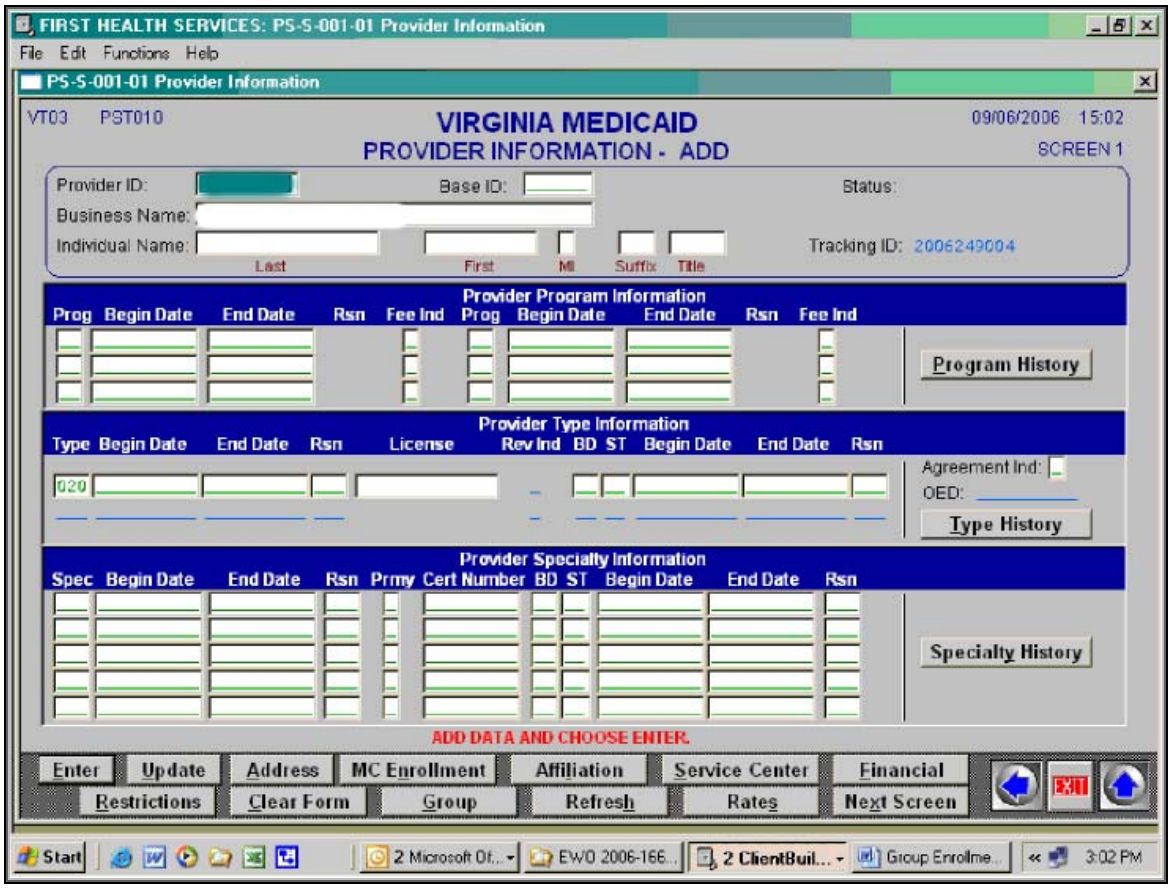


8. If the NPI is missing or invalid, or if other required data is missing or invalid, enter an "R" (Rejected) in the Status field and the appropriate reject reason code in the Reason Code field. (New Reason Code 145 = NPI ID Missing) Click "Enter" and then "Update." The system will generate a Reject letter to be sent to the provider requesting the missing or invalid information.

9. If all edits passed and the record is showing status of "P", enter an "A" (Approved) in the Status field, click "Enter" and then "Update."



10. Place an “A” (Add) in the Select field and click “Provider Info.” VaMMIS will take you to the Provider Info – Add screens.



1.6 Enter Provider Group Data

1.6.1 Task Description

A Group is enrolled using the same provider information screens used for an individual provider, with some exceptions. Use the same procedures for enrolling a Medicaid Provider but change these elements:

- Enter a “G” in the Agreement Indicator Field
- Group Type must be 06 for Group Practice
- Enter Type 04 for the Tax Groups on Page 4 of the Provider Information screen.

Once the Group Provider is added to the Provider database, the system will generate an approval letter for the group indicating that the group has been added with the provided group NPI, but that billing as a group will not begin until January 22, 2007.

After adding the group record, the individual provider(s) listed in the Provider Group Table of the Enrollment Application must be associated to the group record. The Provider Group record will also be updated for the associated group members.

1.6.2 Procedures

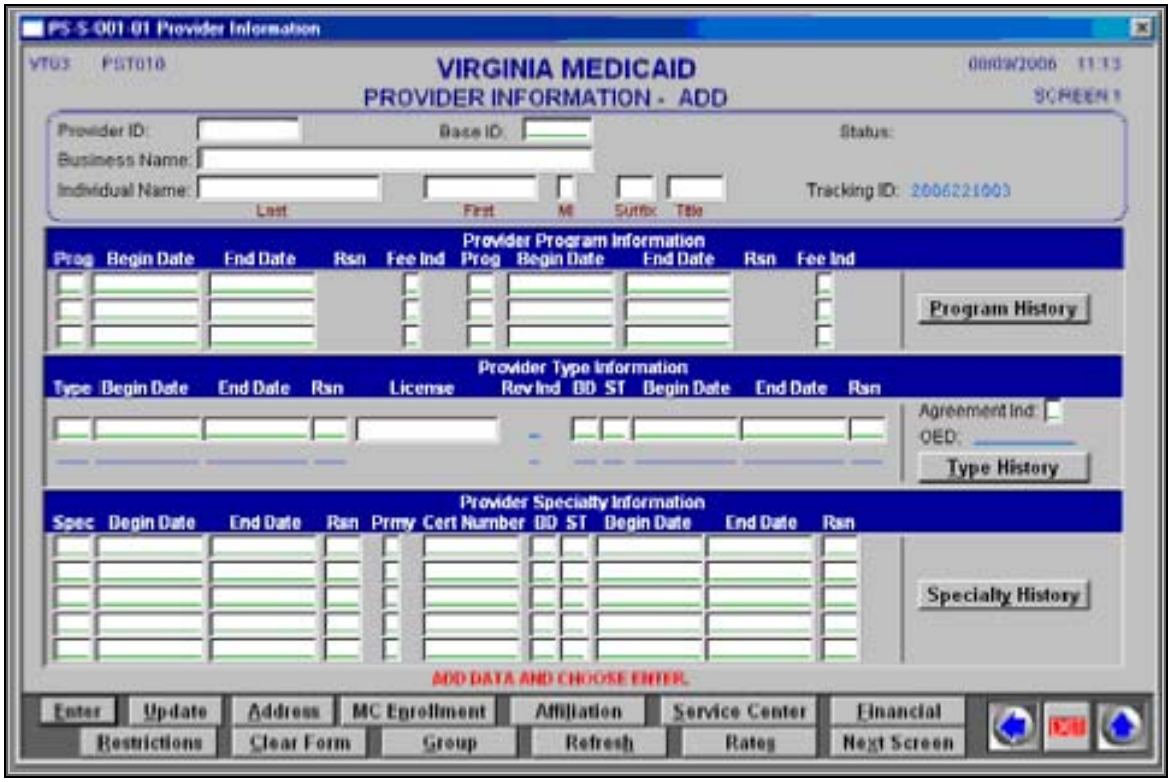
From the VaMMIS Main System Menu:

1. Choose the Provider Icon.
2. You see the Provider Main Menu screen (PS-S-000).
3. Select Group/Provider from the drop-menu in the Selection Field.
4. Choose the Add or Update radio button in the Function Field.
5. Enter the Group Provider Identification Number in the ID Value Field.
6. If no entry is made in the ID Field, enter the Group Provider ID number on the Group/Provider screen and choose Enter to display the record(s).
7. Choose Enter to display the Provider/Group Screen.
8. Search through the data for a current open record. If no record or current open record is found, enter the individual Provider ID that is to be enrolled within the Group ID.
9. After entering data for an Update, choose Enter.
10. If no errors occur, choose Update to save the record.
11. If error messages appear on the bottom of the screen, make correction(s) and choose Enter. When no error messages appear, choose Update to save the data.

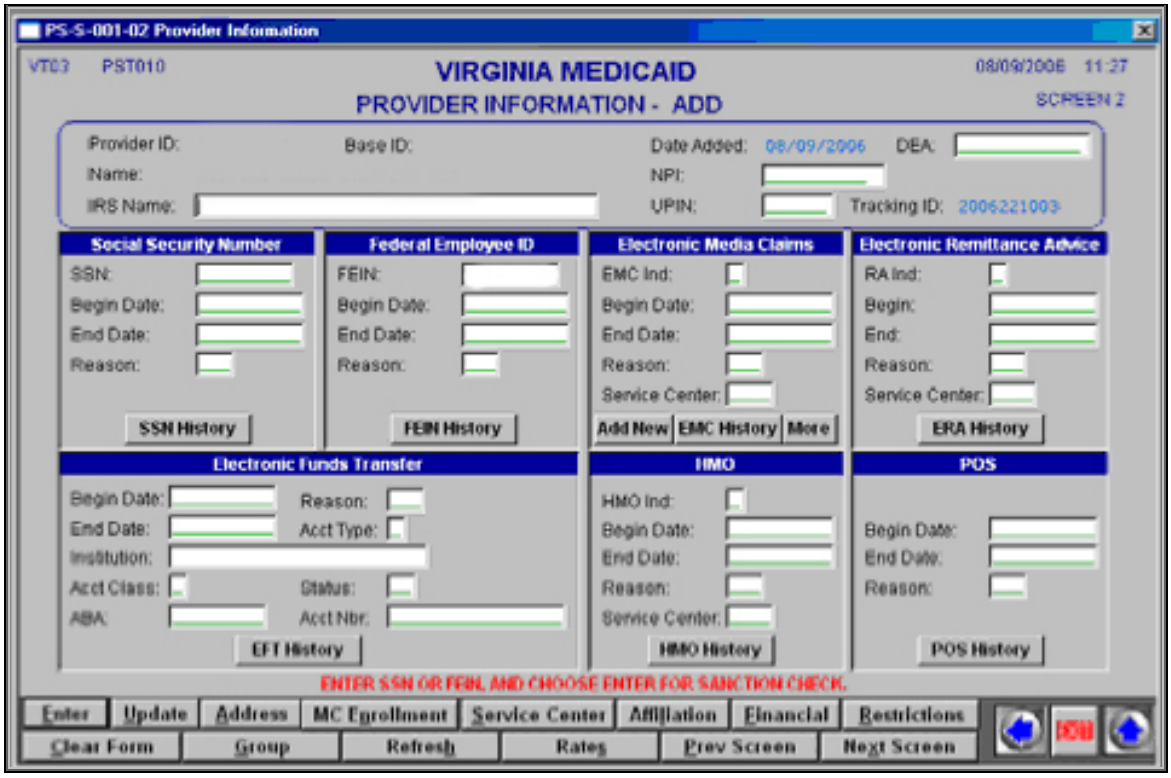
For more details on specific screen navigation and field entries, or specific data elements, refer to the On-line Provider Subsystem User Manual, and/or the Online HELP system.

1.6.3 Complete Required Screens to Enroll Provider Group

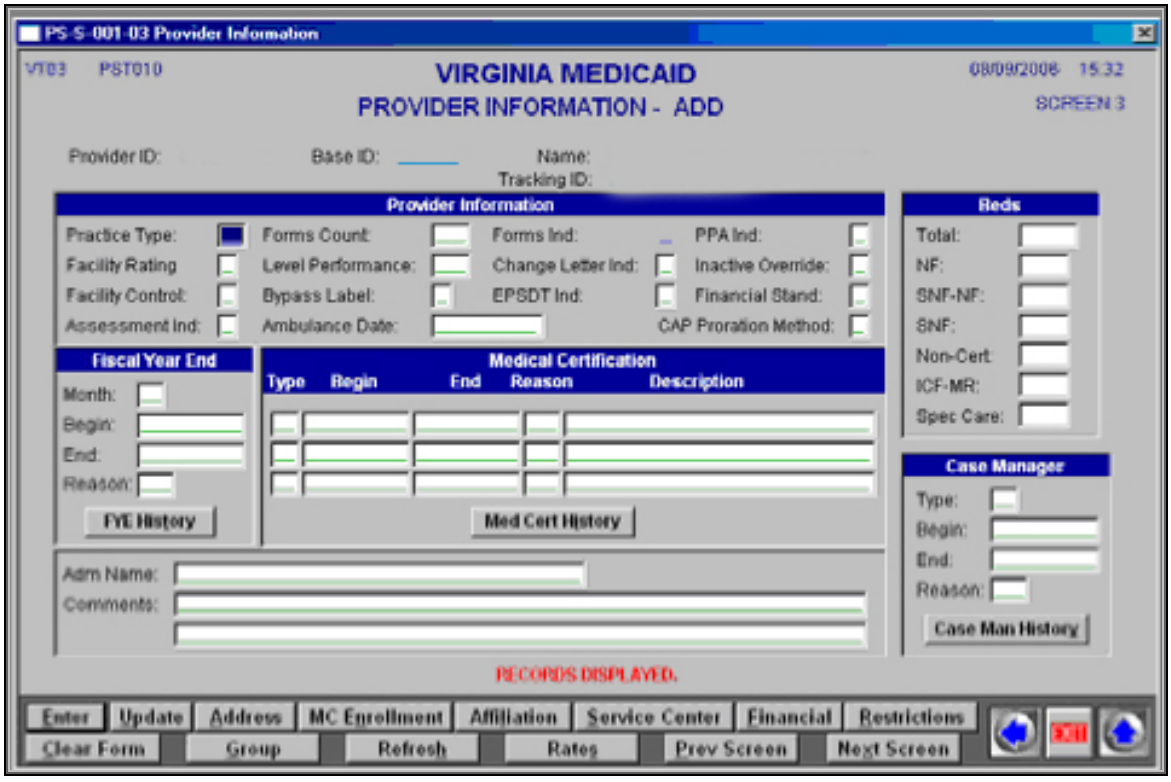
Provider Information Screen



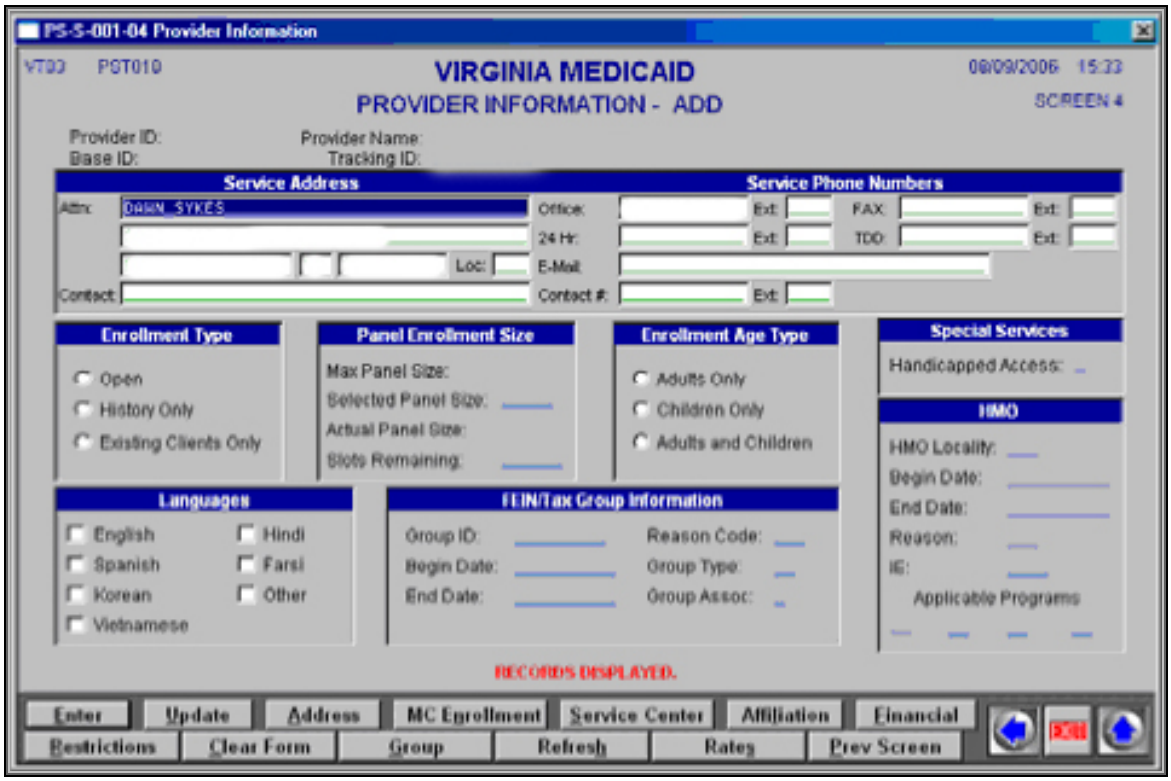
PS-S-001-01



PS-001-02



PS-001-03



PS-001-04

1.6.4 Provider Information Screen Prompts

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-01	Provider ID	A unique identification number assigned to the servicing or billing provider.	N/A	System Assigned
PS-S-001-01	Base ID	A unique	N/A	System Assigned
		Identification number assigned to each provider to associate multiple provider ID numbers with a single provider.		
PS-S-001-01	Status	A code identifying the application status as Active or Inactive.	N/A	System Assigned

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-01	PCP Status	If the provider is enrolled and has an active program code(s) of 02, 03, 04 or 05 the system will display 'PCP'. If the provider is not enrolled in nor has an inactive program code(s) of 02, 03, 04 or 05 the system will display 'Non PCP'.	N/A	System Assigned
PS-S-001-01	Restriction Status	A message indicating the provider is on Restriction or CMM Restriction.	N/A	System Assigned
PS-S-001-01	Name	The name of the servicing or billing Provider.	Enter the group name in the Business Name field in the 40 position free- formatted field.	A group name cannot be an individual.
PS-S-001-01	Tracking ID	Displays the Provider Application Tracking Number associated with the Provider ID.	N/A	System Assigned
PS-S-001-01	Prog	A code indicating the Provider Program(s) in which a provider participates. Required if provider application is Approved.	Enter program codes 01 and 08.	
PS-S-001-01	Begin Date	The date on which the Provider Program Codes begins; MM/DD/CCYY format.	Enter the effective date of the program code as requested by the Provider Group.	
PS-S-001-01	End Date	The date on which the Provider Program Codes ends; MM/DD/CCYY format.	N/A	System Assigned
PS-S-001-01	Program Reason Code	A code identifying the provider Program Reason Code.	000	

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-01	Fee Indicator	A code indicating whether the provider receives management fee for participating in this program. Required for specific Program Code types; 02 and 05.	N/A	System Assigned
PS-S-001-01	Type	A code(s) designating the classification of a provider under the State Plan (e.g., Physician, Dentists Pharmacy, etc.) for the provider type(s).	N/A	The type code is passed from Application Tracking.
PS-S-001-01	Begin Date	The date on which the Provider Type begins; MM/DD/CCYY format.	Enter the same date used for the Program Begin Date.	
PS-S-001-01	End Date	The date on which the Provider Type ends; MM/DD/CCYY format.	12/31/9999	
PS-S-001-01	Rsn	A code identifying the reason code for the Provider Type of a provider's eligibility status.	000	
PS-S-001-01	License	A number assigned by the Virginia licensing agency authorizing a provider to practice within Virginia.	License is Optional for Billing group providers (Agreement indicator = 'G').	
PS-S-001-01	Rev Ind	This code indicates if the License End Date was updated by DHP and if so in which month or if the License End Date was updated manually.	N/A	System Assigned

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-01	BD	Must be a valid Provider Licensing Board code. A code to identify board certifications for licenses.	01	
PS-S-001-01	ST	Must be a valid State code. Required for DHP Provider types. (Optional for other provider types).	Enter the state abbreviation for the state of the license.	
PS-S-001-01	Begin Date	Must be a valid date.	Enter the same date used for the Program Begin Date.	
PS-S-001-01	End Date	Must be a valid date.	09/30/9999	
PS-S-001-01	Rsn	A code identifying the reason code for the Provider License Number of a provider's eligibility status.	000	
PS-S-001-01	Agreement Ind	A code indicating whether the provider has an Indefinite Agreement or not. Is also being used to indicate that the provider is a Group Billing Owner.	G	
PS-S-001-01	OED	The Original End Date of the Provider License. MM/DD/CCYY format.	N/A	System Assigned
PS-S-001-01	Spec	A code(s) identifying a provider's certified medical specialties.	Enter the code or codes that represents the general services of the Provider Group (i.e., Internal Medicine, Pediatrics, etc)	Multiple specialty codes may be entered for the group.
PS-S-001-01	Begin Date	The date on which these provider specialty begins; MM/DD/CCYY format.	Enter the same date used for the Program Begin Date.	

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-01	End Date	The date on which the Provider Specialty ends; MM/DD/CCYY format.	12/31/9999	
PS-S-001-01	Rsn	A code identifying the reason code for the Provider Specialty Code of a provider's eligibility status of a specific specialty.	12/31 /9999	
PS-S-001-01	Prmy	A code indicating whether the specialty is the primary or not.	N/A	System Assigned
PS-S-001-01	Cert Number	The Provider Specialty Certification Number assigned by a certifying board, if applicable.	N/A	
PS-S-001-01	BD	A code identifying each Provider Specialty Certification Board issuing specialty certification to physicians.	N/A	
PS-S-001-01	ST	A code identifying the state that issued the specialty certification.	N/A	
PS-S-001-01	Begin Date	The date on which the Provider Certification begins; MM/DD/CCYY format.	N/A	
PS-S-001-01	End Date	The date on which the Provider Specialty Certification ends; MM/DD/CCYY format.	N/A	

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-01	Rsn	A code identifying the reason code for the status of a provider's eligibility of a specific Specialty Certification Board Code(s).	N/A	
PS-S-001-02	Date Added	The initial date the provider enrollment information for a provider was added to one of the state programs in the Provider database; MM/DD/CCYY format.	N/A	System Assigned
PS-S-001-02	DEA	The identification number assigned to a pharmacy, MD, DO, DDS, etc. by the U.S. Drug Enforcement Agency. GSD 231 is for National Pharmacy Number.	N/A	
PS-S-001-02	NPI	A unique identification number assigned to the provider by the National Provider System to be used by all health care plans.	N/A	NPI is passed from Application Tracking.
PS-S-001-02	IRS Name	The name of the Provider as listed with the Internal Revenue Service (IRS) as appears on the W-9 form.	Enter the legal name of the Provider as it appears on the W-9 form.	
PS-S-001-02	UPIN	A number identifying the Unique Physician Identification Number (UPIN) assigned to the provider by CMS.	N/A	

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-02	Social Security Number Fields	SSN, Begin Date, End Date, and Rsn fields	N/A	Not used for Provider Groups
PS-S-001-02	FEIN	A number assigned to employers by the Internal Revenue Service also known as the Federal Employer Identification Number (FEIN) for tax recording purposes.	N/A	Data entered during Application Tracking process.
PS-S-001-02	Begin Date	The date on which the Provider Federal Employer Identification Number (FEIN) begins; MM/DD/CCYY format.	Enter the same date used for the Program Begin Date.	
PS-S-001-02	End Date	The date on which the Provider Federal Employer Identification Number (FEIN) ends; MM/DD/CCYY format.	12/31/9999	
PS-S-001-02	Rsn	A code identifying the reason code for the Provider Federal Employer Identification Number (FEIN) cancellation of a provider's eligibility status.	000	
PS-S-001-02	Electronic Media Claims Fields	EMC Ind, Begin Date, End Date, Reason, and Service Center fields	N/A	Data entered by the EDI Department.
PS-S-001-02	Electronic Remittance Advice Fields	RA Ind, Begin Date, End Date, Reason, and Service Center fields.	N/A	Data entered by the EDI Department.
PS-S-001-02	Electronic Funds Transfer Fields	Begin Date, Reason, End Date, Acct Type, Institution, Acct Class, Status, ABA, and Acct Nbr fields.	N/A	Date entered by the Finance Department.

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-02	HMO Fields	HMO Ind, Begin Date, End Date, Reason, and Service Center fields.	N/A	Not used for Provider Groups.
PS-S-001-02	POS Fields	Begin Date, End Date, and Reason fields.	N/A	Not used for Provider Groups.
PS-S-001-03	Practice Type	Indicates the type of organization of the practice or group.	06	
PS-S-001-03	Forms Count	A code indicating the number of copies to be sent to a provider related to letters, manuals, etc.	N/A	
PS-S-001-03	Forms Ind	A code identifying whether forms are sent to a provider because of an Add or Reinstate transaction and to what address the forms will be sent.	N/A	
PS-S-001-03	PPA Ind	A code indicating a provider that has a preferred provider agreement with a third party payer.	N/A	
PS-S-001-03	Facility Rating	A code designating the Fiscal classification of a hospital or long-term care facility for tax assessment purposes.	N/A	Not used for Provider Groups.
PS-S-001-03	Level Performance	A code assigned to only HMOs to indicate their performance level.	N/A	Not used for Provider Groups.
PS-S-001-03	Change Letter Ind	A code indicating whether or not a change letter is generated for a provider due to an update to the provider data.	N/A	

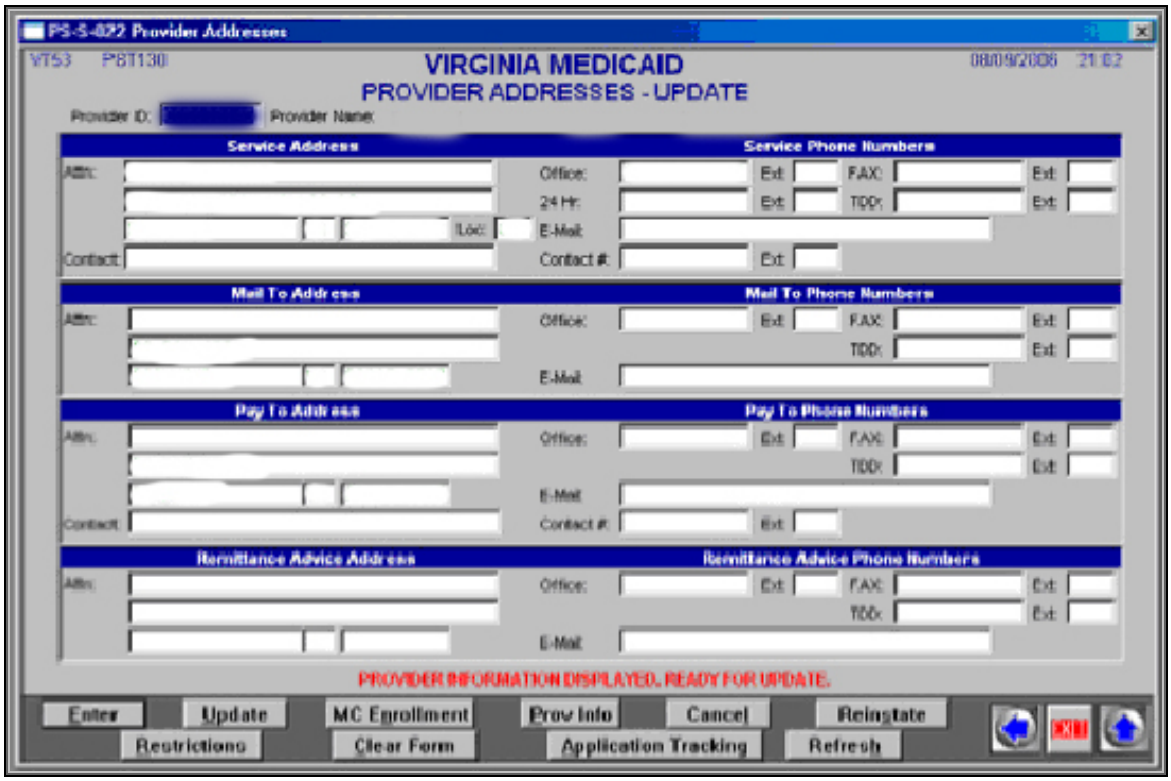
Screen	Data Element	Description	Value You Key	Comments
PS-S-001-03	Inactive Override	Indicates whether the provider will be deemed inactive when producing inactive files and reports.	N/A	
PS-S-001-03	Facility Control	A code designating the	N/A	Not used for Provider Groups.
		Fiscal classification proprietary nature of the facility.		
PS-S-001-03	Bypass Label	A code indicating whether a provider is to have labels printed.	N/A	
PS-S-001-03	EPSDT Ind	A code indicating whether a provider is certified to perform Early Periodic Screening Diagnosis and Testing (EPSDT) services.	N/A	Not used for Provider Groups.
PS-S-001-03	Financial Stand	A code indicating the Provider Financial Standing of HMOs based on financial reviews by DMAS.	N/A	Not used for Provider Groups.
PS-S-001-03	Assessment Ind	A code designating an assessment is allowed for a provider.	N/A	
PS-S-001-03	Ambulance Date	The date a provider signs the ambulance agreement; MM/DD/CCYY format.	N/A	Not used for Provider Groups.
PS-S-001-03	CAP Proration Meth	A code determining the Prorated calculation for an HMO's capitation rate for partial month recipient enrollment.	N/A	Not used for Provider Groups.

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-03	Beds Fields	Total, NF, SNF- NF, SNF, Non Cert, ICF-MR, and Spec Care fields.	N/A	Not used for Provider Groups.
PS-S-001-03	Fiscal Year End Month	The calendar month on which a provider's fiscal year ends; MM format.	Enter the fiscal year end month as provided in the Provider Group Enrollment Application.	N/A
PS-S-001-03	Begin Date	The date on which the Provider Fiscal Year End begins; MM/DD/CCYY format.	Enter the same date used for the Program Begin Date.	
PS-S-001-03	End Date	The date on which the Provider Fiscal Year End ends; MM/DD/CCYY format.	12/31/9999	
PS-S-001-03	Reason	A code identifying the reason code for the Provider Fiscal Year End of a provider's eligibility status.	000	
PS-S-001-03	Medical Certification Fields	Type, Begin, End, Reason, and Description fields.	N/A	Not used for Provider Groups.
PS-S-001-03	Case Manager Fields	Type, Begin, End, and Reason fields.	N/A	Not used for Provider Groups.
PS-S-001-03	Adm Name	The full legal name of the administrator.	N/A	Not used for Provider Groups.
PS-S-001-03	Comments	A free form field for comments related to the provider.	N/A	Not used for Provider Groups.

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-04	Service Address Fields	Attn, Servicing Street Address, Servicing Address City, Servicing State Address, Servicing Zip Code, Serving Locality Code, and Contact fields.	N/A	Data added during Application Tracking process.
PS-S-001-04	Service Phone Numbers Fields	Phone, Ext, Fax, Ext, 24Hr, Ext, TDD, Ext, E-Mail, Contact, and Ext fields.	N/A	Data added during Application Tracking process.
PS-S-001-04	Enrollment Type Fields	Open, History Only, and Existing Only fields.	N/A	Not used for Provider Groups.
PS-S-001-04	Panel Enrollment Size	Max Panel Size, Selected Panel Size, Actual Panel Size, and Slots Remaining fields.	N/A	Not used for Provider Groups.
PS-S-001-04	Enrollment Age Type Fields	Adults Only, Children Only, and Adults and Children fields.	N/A	Not used for Provider Groups.
PS-S-001-04	Special Services	Handicapped Access field.	N/A	Not used for Provider Groups.
PS-S-001-04	Languages Fields	English, Spanish, Korean, Vietnamese, Hindi, Farsi, and Other fields.	N/A	Not used for Provider Groups.
PS-S-001-04	Group ID	The unique provider identification number assigned to a TIN Group. Required and will open only if the Provider ID is shared with another FEIN.	N/A	If the Provider ID is shared with another FEIN, the system will populate this field.

Screen	Data Element	Description	Value You Key	Comments
PS-S-001-04	Reason Code	A code identifying the FEIN/Tax Group Provider Reason Code for the provider's eligibility.	If open, enter 000.	
PS-S-001-04	Begin Date	The begin date of the group affiliation. MM/DD/CCYY format.	If open, enter the current date.	
PS-S-001-04	Group Type	A code to identify the type of group to which a provider belongs.	Enter 004.	
PS-S-001-04	End Date	The relationship end date between two providers.	If open, enter 12/31/9999.	
PS-S-001-04	Group Assoc	A code to indicate whether a provider is a PCP within a group practice or HMO. '0' (Not PCP) '1' (PCP).	N/A	
PS-S-001-04	HMO Fields	HMO Locality, Begin Date, End Date, Reason, IE, and Applicable Programs Fields.	N/A	Not Used for Provider Groups.

After all data has been entered, click “Enter” to view edits. Correct any errors that can be corrected and then click “Update.”



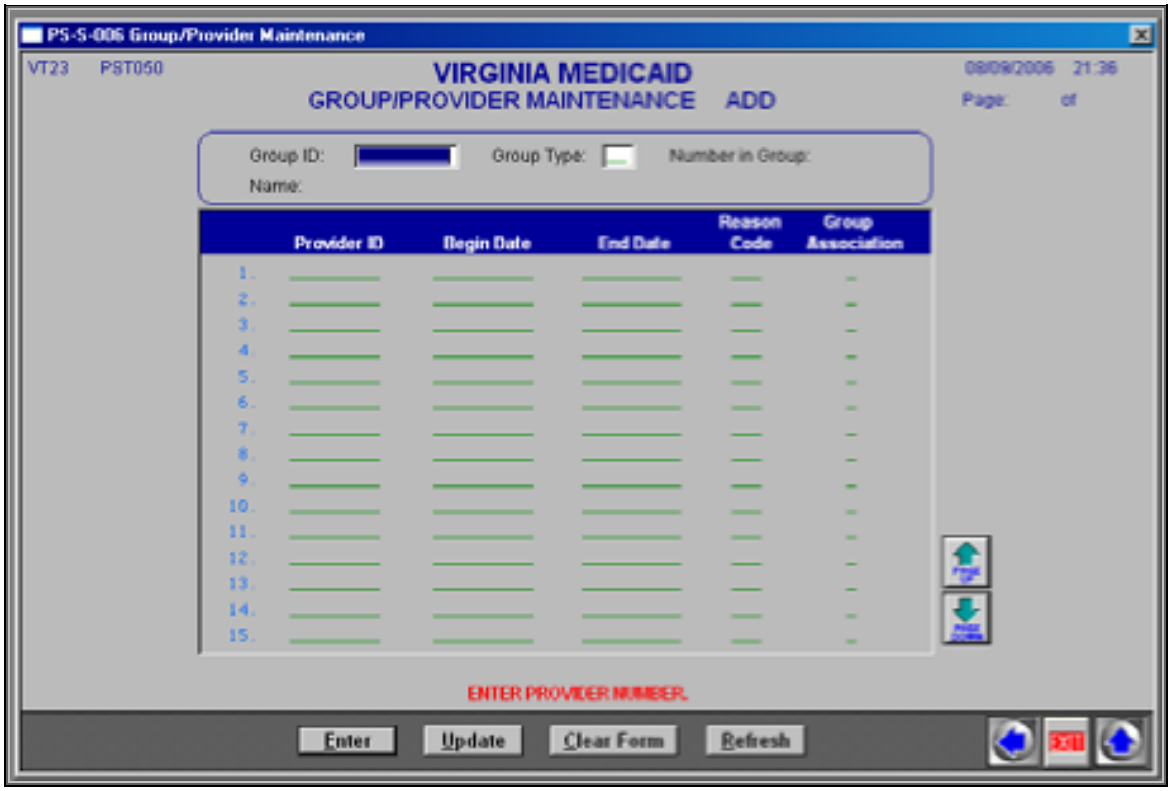
PS-S-022

Screen	Data Element	Description	Value You Key	Comments
PS-S-022	Service Address Fields	Attn, Servicing Street Address, Servicing Address City, Servicing Address State, Servicing Zip Code, Serving Locality Code, and Servicing Contact fields.	N/A	Data added during Application Tracking process.
PS-S-022	Service Phone Number Fields	Phone, Ext, Fax, Ext, 24Hr, Ext, TDD, Ext, E-Mail, Contact, and Ext fields.	N/A	Data added during Application Tracking process.
PS-S-022	Mail To Address Fields	Attn, Mail To Street Address, Mail To Address City, Mail To Address State, and Mail To Zip Code fields.	Enter Mail To Address data from the Address form of the Provider Group Enrollment Application.	

Screen	Data Element	Description	Value You Key	Comments
PS-S-022	Mail To Phone Numbers Fields	Office, Ext, Fax, Ext, TDD, Ext, and E-Mail.	Enter Mail to Phone Numbers from the Address form of the Provider Group Enrollment Application.	
PS-S-022	Pay To Address Fields	Attn, Pay To Street Address, Pay To Address City, Pay To Address State, Pay To Zip Code, Pay To Locality Code, and Pay To Contact fields.	Enter Pay To Address data from the Address form of the Provider Group Enrollment Application.	
PS-S-022	Pay To Phone Numbers Fields	Phone, Ext, Fax, Ext, 24Hr, Ext, TDD, Ext, E-Mail, Contact, and Ext fields.	Enter Pay To Phone Numbers data from the Address form of the Provider Group Enrollment Application.	
PS-S-022	Remittance Advice Address Fields	Attn, Remittance Advice Street Address, Remittance Advice Address City, Remittance Advice Address State, and Remittance Advice Zip Code fields.	Enter Remittance Advice Address data from the Address form of the Provider Group Enrollment Application only if it differs from the Pay To Address data.	
PS-S-022	Remittance Advice Phone Numbers Fields	Phone, Ext, Fax, Ext, 24Hr, Ext, TDD, Ext, and E-Mail fields.	Enter Remittance Advice Phone Numbers from the Address form of the Provider Group Enrollment Application only if it differs from the Pay To Address data.	

After all data has been entered, click “Enter” to view edits. Correct any errors that can be corrected and then click “Update.”

1.6.5 Group/Provider Maintenance Screen



1.6.6 Group/Provider Maintenance Screen Prompts (Data Labels)

Screen	Data Element	Description	Value You Key	Comments
PS-S-006	Group ID	A unique provider identification number assigned to a group.	Enter the 9-digit Provider ID of the Provider Group.	
PS-S-006	Group Type	A code identifying the type of group a provider belongs.	01	And click Enter.
PS-S-006	Number in Group	The number of individual providers for a group.	N/A	System Assigned
PS-S-006	Name	The name of the Group billing or servicing Provider.	N/A	

Screen	Data Element	Description	Value You Key	Comments
PS-S-006	Provider ID	The unique identification number assigned to the servicing provider associated with the group. It is also used to add a provider to a group.	Enter the 9-digit Provider ID of each provider listed in the Provider Group Table of the Enrollment Application and for whom a signed	
		This field occurs multiple times on the screen. If a provider is being added to the Group listed on the screen, the Provider ID entered in this field must exist on the Provider Information database.	Reassignment of Benefits Form was provided.	
PS-S-006	Begin Date	The date of the individual provider began effective with the provider group. MM/DD/CCYY format.	Enter the date that the Individual provider began effective with the provider group.	
PS-S-006	End Date	The date of the individual provider ended with the provider group; MM/DD/CCYY format.	12/31/9999	
PS-S-006	Reason Code	A code identifying the Provider Reason Code for the individual provider being added to a Group/Provider.	000	
PS-S-006	Group Association	A code indicating whether a provider is a PCP within a group practice or HMO.	N/A	

After all data has been entered, click “Enter” to view edits. Correct any errors that can be corrected and then click “Update.”

2.0 Group Re-enrollment Packets

During the NPI Re-enrollment process, potential Group Practice providers identified by the MMIS on the basis of their existing Tax Group 88 records were sent Re-enrollment packets. When the packets are returned with group data, the first step is to enroll the Group Practices following the procedures detailed above. Once this process is complete, the Re-enrollment packets are routed to the Re-enrollment area to capture the NPI for the Group Practice and the member providers identified on the attached roster. Procedures and screens for capturing the NPIs through the Re-enrollment Tracking System are detailed in a separate manual, the Re-enrollment Tracking System Procedures Manual.

The Re-enrollment process for groups may require additional processing in the initial steps of enrolling the groups through Application Tracking and the MMIS. See the sections below for situations that may be encountered with Group Re-enrollment packets.

2.1 Split Re-Enrollment Tracking Groups

If a provider group administrator receives a Re-enrollment Group packet and calls to inquire how to form multiple groups rather than just one: Enrollment:

- Advise the provider to make a copy of the application and roster for each group to be enrolled.
- The administrator then must complete a separate application for each group.
- The administrator must mark a copy of the roster for each group to show which individual providers are to be included with that group, and provide the individual NPI and Reassignment of Benefits form for each.
- The Re-enrollment Tracking Number from the original packet must be included with each group application set.
- If the group administrator says he has already written on the group application, the PEU rep can send him a new group application form from which to make copies.
- When the group applications are returned for processing, enter each group according to the Group Enrolment procedures detailed above. Be sure the Reenrollment Tracking Number is entered for each group on the Application Tracking screen.

2.1.1 Re-enrollment Tracking:

- When entering the Group Re-enrollment NPI data, all roster providers for all the split groups are entered using the original Re-enrollment Tracking Number.
- The new groups will appear as rows in the Roster portion of the screen and the Group NPI is to be entered for the group row. These group lines are populated following the nightly batch

cycle so do not appear until the day following group enrollment through Application Tracking.

2.2 Incomplete Re-Enrollment Tracking Rosters

If you are entering a group from a Re-enrollment packet, check the roster to find any providers who are not excluded, but do not have a valid NPI and/or do not have a properly executed Re-assignment of Benefits form.

2.2.1 Enrollment

- Flag each roster entry that is incomplete by highlighting the row and mark “NPI” for missing/invalid NPI or “ROB” for missing/incomplete Re-assignment of Benefits form.
- Enter group associations for all providers who do have an NPI and do have a valid Re-assignment of Benefits form.
- Do not associate individual providers who have been flagged as incomplete.
- Do not associate any individual providers who have been marked by the administrator as “Exclude”.

2.2.2 Re-enrollment

- When entering the Group Re-enrollment NPI data, you will not be able to capture the NPI for those providers who were flagged with NPI or ROB.
- If an NPI is provided, but the Re-enrollment Tracking systems indicates the NPI is invalid, highlight the roster row and mark it “NPI” (invalid NPI.)
- When all Roster entries are complete, at the header level enter Status “I” for the group and enter the appropriate reason code to indicate the reason the group Reenrollment is incomplete. Use comments as needed to direct the group administrator to the highlighted roster.
- When the reject letter is printed, return the highlighted roster to the group administrator with the letter. A sample Reject letter is included in the Reenrollment Tracking Procedures Manual.

2.3 Roster Providers Identified “Exclude”

If you are entering a group from a Re-enrollment packet, check the roster to find any providers who are excluded, indicated by a 3 or X in the Exclude box on the roster.

2.3.1 Enrollment

- Review the individual provider information on PS-S-001.
- Check [redacted] for recent provider correspondence.
- Determine whether the provider should be terminated (death, etc.) or removed from the 88 group.
- Contact the provider if necessary to determine why he/she is no longer associated with the Tax group 88 record.
- Perform necessary maintenance to correct the individual provider enrollment record.

Re-enrollment:

- On Re-enrollment Tracking, enter an "X" in the roster status for the each excluded provider.

2.4 Missing Required Documents

If the new Group Practice application or a Re-enrollment group packet does not include the required documents to enroll the group,

2.4.1 Enrollment

- Determine all items that are missing.
- Contact the provider and ask for the missing documents to be faxed in order to process the application timely.
- Retrieve the fax and process through normal procedures.
- Image and profile the phone and/or FAX documentation in [redacted].
- If you are unable to contact the provider, route the packet to the Re-enrollment area for processing.

2.4.2 Re-enrollment Tracking

Enter the packet information through Application Tracking and reject the group application using the appropriate incomplete reason codes. A sample Reject letter is included in the Re-enrollment Tracking Procedures Manual.